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December 12, 2012

Ms. Ruby Potter
Health Facilities Coordination Office
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Docket No: 12-16-2334

Dear: Ms. Potter:

On behalf of Fort Washington Medical Center, please accept the enclosed six (6) copies of the responses to the additional information requested in correspondence (letter Riklin to Meacham, October 24, 2014). We look forward to working with you and the other members of the staff of the Commission during the course of their review.

Should you have any questions regarding these responses, please contact Ms. Verna S. Meacham, President and CEO, at 301-686-9010.

Very truly yours,

Richard J. Coughlan

cc: Pamela B. Creekmur

PART I – PROJECT IDENTIFICATION AND GENERAL INFORMATION

Project Description

1. The responses to question 7 and question 14 refer to kitchen equipment that FWMC has already contracted to purchase. The responses say that the costs of the equipment and of modest renovations to accommodate this equipment have been removed from the project. Please provide a more detailed description of the equipment and renovations addressing the following:

   A. Why is this equipment being purchased and associated renovations being undertaken prior to the project?
   B. How do the associated renovations relate to proposed expansion and renovations of the kitchen/dining area?
   C. What will happen to the equipment if the project is not approved?
   D. What will happen to the equipment and renovations if the project is approved? If the equipment will remain as suggested on page 4 of Attachment 2, how will it be incorporated into the expansion and renovation of the kitchen/dining area that is part of the project?

FWMC Response:

A. This equipment was purchased and installed in September, 2014 to improve the food preparation and serving capabilities of the Hospital in its current facility in anticipation of the sale of the Carolyn Boone Lewis Health Care Center. The kitchen there has prepared all of the meals served at FWMC, which are transported in bulk, by truck, where they were transferred to the patient trays and cafeteria. This arrangement never delivered the desired quality of presentation to patients, or those taking their meals in the FWMC cafeteria. The upgraded, full-service kitchen will remain in operation at FWMC.
B. The renovations to the kitchen to accommodate the new equipment will be designed into and relocated to the new, enlarged kitchen and dining areas proposed in the Project.
C. The equipment currently in use in the FWMC kitchen will remain in operation in the current space if the project is not approved.
D. See Response to B. above.

2. Attachment 1, the physical bed capacity inventory table, submitted in response to question 9 has a number of discrepancies. Please revise the Attachment so that it accurately represents the current and proposed physical bed capacity correcting the following discrepancies:

   A. For the existing medical surgical service after project completion the room count of 30 private rooms is not consistent with the proposed project that adds 14 private rooms to the existing facility with minimal renovations to the nursing unit. Therefore, MHCC staff presumes that the new private rooms will be added to the current 16 semi-private rooms and the one private room for a total after the project of 16 semi-private rooms and 15 private rooms, which would provide the capacity for 47 beds as indicated by you in the Attachment. Please revise the table to reflect the correct number of rooms by room type physical capacity or explain what changes will be made to change the physical capacity of the existing rooms.

   B. For the critical care beds under both existing physical capacity and physical capacity after the project, the number of semi-private rooms is identified as 3. MHCC staff believes that the correct number is one, although this room contains three beds as reflected in the notes. Please revise the bed inventory table to reflect this correction.

FWMC Response:

A. The existing inpatient service at FWMC, for both medical/surgical (M/S) and ICU, is comprised of 19 patient rooms, of which two are ICU rooms and seventeen are M/S rooms. These 19 rooms, of which 16 are semi-private rooms, accommodate 37 beds. The physical capacity of 18 of the 19 existing patient rooms of FWMC are not intended to change as part of this project; one private patient room, currently designated as the Hospital's isolation room, will be removed in order to provide a seamless interface with the proposed 15-room addition. A second existing semi-private room will be converted to a private patient room that will be designated for isolation.

   In addition to these changes, seven of the existing semi-private rooms will be converted to non-inpatient uses, including three rooms for outpatient observation visits, two rooms for offices, one room for physical therapy, and one room for staff.

   After project completion, FWMC inpatient rooms will consist of 11 of the 19 patient rooms currently in the facility plus 15 additional patient rooms, for a total of 26 patient rooms. All of the 15 additional inpatient rooms to be added in the project's new 2-story addition will be sized and constructed as private rooms, such that the physical bed capacity of FWMC will decrease from 37 beds to 36 beds, in order to preserve the availability of one private isolation room in the existing nursing unit. Nevertheless, FWMC intends to operate 25 of its 26 inpatient rooms as private rooms, the lone exception being the room where the three ICU beds are currently located, and that patient room will not be changed or impacted as part of this project.

Because of the conversion of seven semi-private rooms to private rooms, the conversion of inpatient rooms to alternative uses, the available inpatient bed supply of staffed and operating MSGA beds at FWMC will actually decrease from 37 beds to 28 beds, including its 4 ICU beds. (See Chart below).

No actual bed increase is being proposed as a result of this project, consistent with the utilization projections shown on TABLE 1 and the resulting future licensed bed counts. On any given day, consistent with current practice, patient rooms not occupied by inpatients will be available to serve hospital outpatients, including observation patients, of which three semi-private rooms will be specifically designated and staffed for that purpose.

B. As shown on the chart below, the two-room, four bed ICU will not be changed as a result of this project.

Current Patient Rooms and Physical Bed Capacity		
Current Rooms	Service	Beds
205	ICU	3
207	ICU	1
210	M/S	2
212	M/S	2
214	M/S	2
216	M/S	2
218	M/S	2
220	M/S	2
222	M/S	2
224	M/S	2
226	M/S	2
228	M/S	2
232	M/S	2
234	M/S	2
236	M/S	2
238	M/S	2
240	M/S	2
242	M/S	2
244	M/S	1
TOTAL = 19		37

Proposed Patient Room and Physical Bed Capacity: Seven Rooms Converted		
Current Rooms	Service	Beds
205	ICU	3
207	ICU	1
210	M/S	2
212	M/S	2
214	M/S	2
216	M/S	0
218	M/S	0
220	M/S	0
222	M/S	0
224	M/S	0
226	M/S	0
228	M/S	0
232	M/S	2
234	M/S	2
236	M/S	2
238	M/S	2
240	M/S	2
242	M/S	1
244*	M/S	0
TOTAL = 18		21

*Room 244 will be removed for Interface with New Construction

Proposed Rooms	Service	Total Beds
1	M/S	1
2	M/S	1
3	M/S	1
4	M/S	1
5	M/S	1
6	M/S	1
7	M/S	1
8	M/S	1
9	M/S	1
10	M/S	1
11	M/S	1
12	M/S	1
13	M/S	1
14	M/S	1
15	M/S	1
TOTAL = 15		15
TOTAL = 33		36

Proposed Patient Room and Actual Staffed Bed Allocation		
Current Rooms	Service	Beds
205	ICU	3
207	ICU	1
210	M/S	1
212	M/S	1
214	M/S	1
216	M/S	0
218	M/S	0
220	M/S	0
222	M/S	0
224	M/S	0
226	M/S	0
228	M/S	0
232	M/S	1
234	M/S	1
236	M/S	1
238	M/S	1
240	M/S	1
242	M/S	1
244*	M/S	0
TOTAL = 12		13

*Room 244 will be removed for Interface with New Construction

Proposed Rooms	Service	Total Beds
1	M/S	1
2	M/S	1
3	M/S	1
4	M/S	1
5	M/S	1
6	M/S	1
7	M/S	1
8	M/S	1
9	M/S	1
10	M/S	1
11	M/S	1
12	M/S	1
13	M/S	1
14	M/S	1
15	M/S	1
TOTAL = 15		15
TOTAL = 27		28

Proposed Uses for Converted Rooms and Unlicensed Beds
Outpatient Observation
Outpatient Observation
Outpatient Observation
Physical Therapy
Dietician Office
Case Management Office
Multi-Disciplinary Break Room

3. In response to question 15, FWMC states that the project drawings have not changed since the previous submission. This indicates that the amount and mix of new construction and renovations being proposed has not changed. However, there are discrepancies between the square footage detail presented in this modification and square footage detail presented in the original application and subsequent clarifications. There are also some square footage inconsistencies within the modification itself. It is important that proposed changes in hospital square footage be correctly and consistently represented so that MHCC staff analysis of the reasonableness of cost including analysis of hospital construction cost, standard B7 (the MVS analysis), can precede smoothly. Therefore please correct and/or reconcile the following discrepancies and inconsistencies and submit revised Chart 1s and floor plans, if necessary.

   A. In the project description (Attachment 2), the last paragraph of page one refers to a new two story addition of 7,267 SF, identified as section one. It is not clear what the 7,267 SF refers to. This paragraph indicates that the first story of this section will house an expanded Emergency Department ("ED") and the second story will house additional private patient rooms. The table at the end of the project description[1] specifies that there will be 8,127 SF of space added for the ED and the observation unit (6,460 SF for the ED and 1,677 for the observation unit).
      i. The first discrepancy is that 6,640 plus 1,677 equals 8,137 SF not 8,127 SF. Please correct or explain this discrepancy and ensure that Chart 1 on page 6, which also reports the ED addition at 8,127 SF, and the MVS analysis and the analysis of the consistency of the proposed plans with standard 14, ED treatment capacity and space, is based on the correct space.
      ii. Based on the details reported on the table at pages 2 and 3 of Attachment 2, It would appear that the two story addition is either 14,744 SF or 14,754 SF not 7,267 SF. Please correct or explain the reference to 7,297 SF.

   B. The description of the fourth section of the project, which involves the Surgery Department, indicates that there will be 3.522 SF of new construction or new construction and renovation. On page 4 of the description, the table indicates that there will be 1,660 SF of new construction and 1,160 SF of renovation which equals 2,820 SF not 3,522 SF. In addition the specification of 1,160 SF of renovations is not consistent with the 1,112 SF specified in Chart 1 on page 8 of the modification and on page 6 of the November 16, 2012 response to additional information questions. Please correct or reconcile these numbers and insure that the project description narrative, project description table, and the Chart 1 for the Surgery Department are consistent.

   C. The space to be added for the Front Entry/Lobby is identified as 1,238 SF on page 7 of the modification and on page 9 the space to be renovated is identified as 2,856 SF. However, on page 1 of the July 10, 2012 responses to additional questions new construction is reported to be 1,665 SF and renovations to be 2,429 SF. Please correct or reconcile this discrepancy.

FWMC Response A., B., and C.

[1] The information in the table at the end of the project description is the same as reported in the table on page 1 and 2 of FWMC's May 10, 2012 response to the first completeness questions.

The proposed square footage statistics for the project are shown below. It should be noted that the project will involve new construction and renovations, as well as surface upgrades to the existing hospital facilities.

1) Emergency Department and Observation Unit			
AREAS:	S.F.	TREATMENT BAYS	S.F. PER TREATMENT BAY
Existing	2,800 S.F	14	200
After Completion	10,937 S.F	34	322
New Construction	8,137 S.F.		
Renovation	1,102 S.F.		
Adjacent Area Surface Upgrade	1,299 S.F.		
1) a. Emergency Department (excluding Observation)			
Existing	2,800 S.F.	14	200
After Completion	9,260 S.F.	28	331
New Construction	6,460 S.F.		
1) b. Observation Unit			
		BAYS	S.F./BAYS
All New Construction 1,677 S.F.		6	280
2) MSGA			
AREAS:	S.F.	BEDS	S.F./BED

Existing			11,226 S.F		37	303
	After Completion		17,842 S.F		49	364
	New Construction		6,617 S.F.			
	Renovation		450 S.F.			
	Adjacent Area Surface Upgrade 901 S.F.					
	Excluding CCU				47	358
3) Surgery Department						
AREAS:			S.F.		NUMBER of O.R.'s	
Existing			6,660 S.F		3	
	After Completion		8,320 S.F		3	
	New Construction		1,660 S.F.			
	Renovation			1,160 S.F.		
	Adjacent Area Surface Upgrade 1,860 S.F.					
4) Dietary						
AREAS:			S.F.			
Existing			2,355 S.F			
	After Completion		4,622 S.F			
	New Construction		2,267 S.F.			
	Renovation		2,590 S.F.			

	Adjacent Area Surface Upgrade 1,019 S.F.	
Existing		1,981 S.F
	After Completion	4,094 S.F
5) Main Entry/Lobby		
AREAS:		S.F.
Existing Entry/Lobby		1,981 S.F
Existing Canopy		448 S.F
	After Completion	4,094 S.F
	New Construction	1,665 S.F.
	Renovation	2,429 S.F.
6) Energy Building		
	All New Construction	3,000 S.F.

REVISED Chart 1. Project Construction Characteristics and Costs			
Base Building Characteristics	Complete if Applicable		
	NEW CONSTRUCTION		
	ED Addition	Surgery Addition	MS Bed Addition
Class of Construction			
Class A	X	X	X
Class B			
Class C			
Class D			
Type of Construction/Renovation			
Low			
Average			
Good	X	X	X
Excellent			
Number of Stories	1	1	1
Total Square Footage			
First Floor	8,137	1,660	
Second Floor			6,617
Third Floor			
Perimeter in Linear Feet			
First Floor	435	200	
Second Floor			435
Third Floor			
Wall Height (floor to eaves)			
First Floor	13	16	
Second Floor			13
Third Floor			
Elevators			
Type *Passenger Freight*			
Number			
Sprinklers (Wet or Dry System) Wet			
Type of HVAC System	Central/VAV w/Reheat	Central/VAV w/Reheat	Central/VAV w/Reheat
Type of Exterior Walls	Curtainwall & Brick Veneer	Curtainwall & Brick Veneer	Curtainwall & Brick Veneer

REVISED Chart 1. Project Construction Characteristics and Costs			
Base Building Characteristics	Complete if Applicable		
	NEW CONSTRUCTION		
	Lobby/Front Entrance	Energy Building	Dietary/Kitchen
Class of Construction			
Class A	X	X	X
Class B			
Class C			
Class D			
Type of Construction/Renovation			
Low			
Average			
Good	X	X	X
Excellent			
Number of Stories	1	1	1
Total Square Footage			
First Floor	1,665*	3,000	2,267
Second Floor			
Third Floor			
Perimeter in Linear Feet			
First Floor	257	265	303
Second Floor			
Third Floor			
Wall Height (floor to eaves)			
First Floor	14	20	14
Second Floor			
Third Floor			
Elevators			
Type *Passenger Freight*			
Number			
Sprinklers (Wet or Dry System) Wet			
Type of HVAC System	Central/VAV w/Reheat	Central/VAV w/Reheat	Central/VAV w/Reheat
Type of Exterior Walls	Curtainwall & Brick Veneer	Curtainwall & Brick Veneer	Curtainwall & Brick Veneer

*includes new canopy.

REVISED Chart 1. Project Construction Characteristics and Costs			
Base Building Characteristics	Complete if Applicable		
	RENOVATIONS		
	ED Addition	Surgery Addition	MS Bed Addition
Class of Construction			
Class A	X	X	X
Class B			
Class C			
Class D			
Type of Construction/Renovation			
Low			
Average			
Good	X	X	X
Excellent			
Number of Stories	1	1	1
Total Square Footage			
First Floor	1,102	1,160	
Second Floor			450
Third Floor			
Perimeter in Linear Feet			
First Floor	435		
Second Floor			435
Third Floor			
Wall Height (floor to eaves)			
First Floor	13	16	
Second Floor			13
Third Floor			
Elevators			
Type *Passenger Freight*			
Number			
Sprinklers (Wet or Dry System) Wet			
Type of HVAC System	Central/VAV w/Reheat	Central/VAV w/Reheat	Central/VAV w/Reheat
Type of Exterior Walls	Curtainwall & Brick Veneer	Curtainwall & Brick Veneer	Curtainwall & Brick Veneer

REVISED Chart 1. Project Construction Characteristics and Costs			
Base Building Characteristics	Complete if Applicable		
	RENOVATIONS		
	Lobby/Front Entrance		Dietary/Kitchen
Class of Construction			
Class A	X		X
Class B			
Class C			
Class D			
Type of Construction/Renovation			
Low			
Average			
Good	X		X
Excellent			
Number of Stories	1		1
Total Square Footage			
First Floor	2,429		2,590
Second Floor			
Third Floor			
Perimeter in Linear Feet			
First Floor	270		303
Second Floor			
Third Floor			
Wall Height (floor to eaves)			
First Floor	14		14
Second Floor			
Third Floor			
Elevators			
Type *Passenger Freight*			
Number			
Sprinklers (Wet or Dry System) Wet			
Type of HVAC System	Central/VAV w/Reheat		Central/VAV w/Reheat
Type of Exterior Walls	Curtainwall & Brick Veneer		Curtainwall & Brick Veneer

PART II - Project Budget

4. The sum of the renovation costs (lines A1b(1) through (4) equals $2,262,035 not the $2,265,035 reported on page 11. This discrepancy is carried through the budget. Please correct this error and make sure that, if the total uses of funds change, the sources of funds are also changed.

FWMC Response:

On the Project Budget, the line item for b. (2), "Fixed Equipment (not included in construction)" should read: $99,363, not $96,363. The $2,265,035 is correct.

5. Regarding the Notes to the Project Budget, please provide the following clarifications:

   A. For note 5, please specify the source of the inflation factors used in the calculations and explain why the calculation of the estimated future inflation starts with $13,836,497 when the table appears to indicate that inflation is calculated based on the total current capital cost excluding permits and A&E fess. Total Current Capital Costs ($17,144,189) minus permits ($181,240 and $39,737) and A & E fees ($1,087,429 and $238,420) equals $15,597,363 not $13,836,497.

   B. Regarding note 6, please provide the following clarifications:
      i. What capital acquisition will be purchased with the AMPO funds after the project is completed and operational and why are such purchases not part of the project costs and the AMPO funds a source of funds?
      ii. The reference on page 14 to 2015 no longer appears to be reasonable for spending the AMPO funds after project is operational since it is already October 2014 and the response to question 11 indicates that the project will not be completed until 36 months after a CON approval. Please correct or explain the reference to 2015.

FWMC Response:

A. The source of the inflation factors used in the calculations were those obtained from HEERY International, Inc., construction cost consultants to FWMC for this project. For the CON Application prepared in April, 2012, HEERY estimated 2.7% inflation per year, which the actual inflation factors averaged 1.43%. HEERIY is also the source of the 2014 and 2015 inflation factors submitted on September 5, 2014. In addition to the Permit and A&E fees, the assumptions regarding the future construction cost inflation computation also excluded the estimated costs for fixed equipment (not included in construction) of $1,156,564 and site preparation of $604,302. Those estimated costs for these were $1,760,866, and reduced the total current (as of August, 2014) construction costs of the project to $13,836,497, to which the inflation factors shown on Note 5 were applied.

B. i. There are no plans for capital acquisition to be purchased with the AMPO funds after the project is completed. AMPO means "amount to make project operational," and is a contingency fund created by the financing plan proposed for the project. According to that plan, "unneeded to make the project operational" AMPO funds can be spent after HUD accepts the project as completed; therefore, by definition the AMPO funds have not been included in the budget for the project as a planned expenditure. Following this assumption, the AMPO funds are shown to be used by FWMC to specifically fund non project-related items, such as upgraded medical equipment.

ii. The reference to the completion date of the project should be changed from 2015 to 2017. The revised target dates assume a more rapid process for completion of construction documents and financing approval in order to assure completion of the new construction and occupancy of the two-story building for the expanded ED and additional private patient rooms.

PART III – CONSISTENCY WITH GENERAL REVIEW CRITERIA

State Health Plan - General Standards

6. Standard 1, Information Regarding Charges, the website link does not work but the link in the May 10, 2012 response to completeness questions (p. 11) www.fortwashingtonmc.org does work. The information about the list of charges says the charges are updated quarterly, as required, but the list does not specify when it was last updated. Please add the information on when the list was last updated to the website.

FWMC Response:

This week, the FWMC website was updated, consistent with Standard 1. Please see Attachment A.

7. Regarding Standard 2, Charity Care Policy, p. 17 and Attachment 3

   A. The standard requires that the hospital make a determination of probable eligibility with two business days of receipt of a patient's application for charity care services or medical assistance or both and that this be included in the policy, but the policy says a letter of conditional approval of probable eligibility will be sent to the patient within 3 business days of a completed application. The policy must be revised to clearly indicate that a determination of probable eligibility will be made within two business days.

   B. Reference to a completed application as a condition of a determination of probable eligibility raises a concern as to the nature of the application and what constitutes a completed application. Please submit a copy of the application and clearly indicate what constitutes a completed application. Describe the process of reviewing applications for charity care and/or medical assistance and first making a determination of probable eligibility and then a final determination.

   C. The standard also requires that the policy address the minimum required notice (to the public, in departments that have early contact to the patients and to the individual patients). While the response to this standard states that notices regarding the Hospital's charity care policy are posted in key departments, the posting of the notices is not part of the policy. The policy must be revised to include how and where notices will be distributed to the general public, where the notices will be published in the hospital and how notices will be provided to individual patients and their representatives.

   D. It is not clear whether the copy of the notice provided in Attachment 3 is the notice to the public, which are typically published in newspapers or the notice that is posted in key departments. Please clarify and provide a copy of the other notice.

FWMC Response:

A. There was a dated version of the brochure included in the application submitted on September 5, 2014. A copy of the current policy in use is attached which clearly states determination of eligibility with two business days is found at Attachment B.

B. The application used by the Hospital is the Maryland Uniform Financial Assistance Application. A copy is found at Attachment B.

C. Attachment 3 to the CON application submitted on September 5, 2014 was an informational brochure. The hospital policy at Attachment B spells out the information as required.

D. Attachment 3 to the CON application submitted on September 5, 2014 is the informational brochure handed to each patient at the time they are seen at the hospital seeking services and the document available from the hospital's website. The Notice to the Public is also found at Attachment B and is posted in the various departments in the hospital.

8. Quality
   Given that the accreditation by the Joint Commission on the record in this review was valid until November 2013 and the Hospital's Maryland Department of Health and Mental Hygiene license also expired in November 2013, please submit the current accreditation and license.

FWMC Response:

The current FWMC accreditation and licensure documents are found at Attachment C to these responses.

State Health Plan - Project Review Standards

9. Regarding the Need standard, Identification of Bed Need and Additional Beds, FWMC currently has the capacity for 37 and is proposing to add 14 private patient rooms, which would result in the physical capacity for 51 beds. Therefore, FWMC is proposing additional MSGA bed capacity and the standard is applicable. Please respond the following questions:

   A. While it appears that the physical capacity would be 51 beds, MHCC staff believes it is FWMC intention to operate most of the resultant 33 rooms as private rooms. Please confirm whether this is correct or not. If it is correct, please provide the following clarifications:
      (i) Submit an inventory worksheet similar to Attachment 1 that clearly indicates how FWMC intends to operate the rooms specifying the operating capacity of each room and any changes that will be made to the existing multi-bed rooms.
      (ii) Please explain how excess rooms would be used given that the hospital would have 33 rooms and is currently licensed for 31 beds and you project that it will be licensed for 29 beds by the time the project is completed.

   B. If FWMC does not intend to operate most of the rooms as private rooms the additional beds significantly exceed the Hospital's current count of licensed beds and exceed the minimum jurisdictional bed need projections. If such is the case, FWMC must justify the need for the additional bed capacity pursuant to subpart (iii) or (iv) of the standard.

FWMC Response:

FWMC does not agree that FWMC is proposing additional MSGA bed capacity in this CON Application, as defined in the standard.

The standard found at COMAR 10.24.10.04 B.(2) Identification of Bed Need and Addition of Beds reads as follows:

Only medical/surgical/addictions ("MSGA") beds and pediatric beds identified as needed **or currently licensed (emphasis added)** as shall be developed at acute care general hospitals. By definition, beds and rooms available for outpatient services or other non-inpatient uses are not licensed and counted in the MSGA bed inventory of FWMC.

Currently, the FWMC is licensed for 31 MSGA beds. Following implementation of this Project, FWMC will be licensed for 29 beds, a decrease, not an increase in MSGA beds.

As discussed in Response to Question 2 above, FWMC is proposing an increase in patient rooms from 19 rooms to 26 rooms, and an decrease in physical bed capacity from 37 beds to 36 beds. Therefore, this standard is not applicable. The actual number of MSGA beds currently available for inpatients at FWMC, by law, is 31 beds, as reported by the MHCC on TABLE 1. Licensed Acute Care Beds by Hospital

and Service, FY 2015. At no time does FWMC anticipate increasing its MSGA bed capacity above the 31 MSGA beds currently licensed. For this reason again, the Standard is not applicable.

A. As stated in response to Question 2, FWMC intends to operate 25 of its 26 total inpatient rooms as private rooms following completion of the project. Sixteen of the 19 patient rooms at FWMC are currently semi-private rooms. Following completion of the project, one of the sixteen semi-private patient rooms will be removed in order to provide a seamless interface between the existing nursing unit and the proposed 15 room expansion. Eight of the remaining semi-private rooms will be operated as private rooms following the completion of the project and the addition of 15 patient rooms. The remaining seven semi-private rooms in the Hospital that are not licensed or occupied by inpatients will be converted to two offices, one staff room, one PT room, and three rooms for providing outpatient services, including outpatient observation visits.
B. There is no MSGA bed increase being proposed in this Project.

10. The cost effectiveness standard requires that the applicant develop both capital and operational cost estimates for each alternative. While the response provides capital cost estimates for each alternative, operational cost estimates were not provided. Please provide such operational cost estimates and clearly state and explain the assumptions made in preparing the estimates.

FWMC Response:

Two proposed alternatives to the proposed project are discussed below.

The first alternative is the $57M expansion project proposed and approved by the MHCC in 2006. That expansion project involved 70,000 gsf of new construction, 14,000 gsf of renovations, a three-story addition, 33 additional patient rooms and 51 total beds for medical/surgical services, an expanded Emergency Department, Surgery, and other hospital departments. Operational cost projections to operate the expanded hospital in 2010 were $47,347,000, expressed in 2006 dollars.

The second alternative is the current project without the private room expansion on the second floor of the 2-story patient tower. We have estimated that the capital cost savings would be approximately $3 Million, to account for reductions in construction costs and related capital for furnishings and equipment related to the additional private patient rooms. We have recalculated the operational cost savings to the Hospital for this alternative, which are found at Attachment H.

11. In responding to standard 7, Construction Cost of Hospital Space, the development of the MVS benchmark and the comparison to the estimated project costs presented in Attachment 5 combines the new construction and renovations. It has been a long standing MHCC practice to develop separate benchmarks and comparisons for the new construction and the renovations. Please prepare such comparisons.

FWMC Response:

Project Budget Item: 2014 Cost Estimates	
New Construction	$7,400,449
Site Preparation	$604,302
Architectural/Engineering Fees	$1,087,429
Permits	$181,240
Capitalized Construction Interest	$460,395.99
Contingencies	$1,241,823
Other	$746,984
TOTAL	$11,722,622
Adjustments for Extraordinary Costs*	$587,002
Adjusted Total for MVS Comparison	$11,135,620
Estimated Square Feet	25,320
Adjusted Cost/Sq. Ft.	$439.80
MVS Benchmark Cost/Sq. Ft.	$433.94
Total Over (Under) MVS Benchmark	$5.86

Project Budget Item: 2014 Cost Estimates	
Renovations	$1,887,515
Site Preparation	$0
Architectural/Engineering Fees	$238,420
Permits	$39,737
Capitalized Construction Interest	$117,426
Contingencies	$316,732
Other	$190,521
TOTAL	$2,790,351
Adjustments for Extraordinary Costs*	$0
Adjusted Total for MVS Comparison	$2,790,351
Estimated Square Feet	8,110
Adjusted Cost/Sq. Ft.	$344.06
MVS Benchmark Cost/Sq. Ft.	$560.48
Total Over (Under) MVS Benchmark	-$216.42

12. Many of changes that are cited as improving operational efficiency on pages 36 through 44 relate to staffing efficiencies, but staffing as measure by FTEs per adjusted occupied bed are projected to increase in the years after the project is completed (2018 and 2019). The projections in Attachment 6 show that the FTEs per adjusted occupied bed are projected to increase from a low of 4.88 in 2014 to 5.30 in 2018 and 5.33 in 2019. Given the projected increases in this indicator, please explain (and quantify) the claim of improved operational efficiency gained through staffing efficiencies.

FWMC Response:

While the FTEs per adjusted occupied bed are projected to increase from 4.88 to 5.33, the acuity of the patients seen in the hospital are projected to rise by 11.44% (from .7966 in 2014 to .8877 in 2019). This increase in acuity or intensity accounts for the increased FTEs per adjusted occupied bed. Lower acuity cases will be replaced by more acute cases over the course of five years as the hospital reduces readmissions, preventive quality indicators and hospital acquired conditions. The computations of the projected change in hospital case-mix are shown at Attachment D.

13. Regarding the financial Feasibility standard, please provide the following additional information and clarifications:

    A. Given the projected increase in FTEs per adjusted occupied bed cited in the previous questions, demonstrate that the increase is reasonable.
    B. Demonstrate that staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels as required by subpart (iii) of the standard

FWMC Response:

A. As we discussed in the previous question, the increase in FTEs per adjusted occupied bed is reasonable based on the increase in the acuity of the patients which increases by 11.44% over the projection period. As stated in question 12, increase in case mix would account for the change and it appears reasonable.

B. The staffing and overall expense projections were updated based on the 2013 audited financial report and supporting statistics and reconciled to current performance. Known changes in performance and contractual changes have been incorporated into the projections. Expected changes in volume and the elimination of lower acuity cases along with the projected changes in case mix were taken into consideration in development of the projections. We believe our methodology is consistent with the standard.

14. Regarding the response to Standards 14 and 15 regarding Emergency Department expansion and treatment capacity and space, please respond to the following:

    A. In classifying the current and proposed ED operations as low or high range based on the parameters in the most recent edition of *Emergency Department Design: Practical Guide to Planning for the Future*, on page 50, please classify FWMC in terms of the age of patients.
    B. Does FWMC consider its primary and secondary service area for ED services to be the same as its primary and secondary service area for MSGA services as identified in Attachment 6? If not, please identify FWMC's existing primary service area for ED services.
    C. While FMC is proposing an ED of approximately 11,000 dgsf, the ACEP guidelines for a low range operation with 40,000 annual visits suggest approximately 22,000 dgsf. While MHCC staff recognizes that the proposed ED space is a significant improvement on current operations, please explain how the proposed space is consistent with the guidelines as required by the standard. Identify any space that is and will be outside the ED that is typically included in ED space.

FWMC Response:

A. As shown below, there were 44,302 outpatient ED visits reported by FWMC for the 12-month period ending June 30, 2012. 5,272 (12%) of those visits were by patients age 65+. We don't believe that the age distribution of the patients to the FWMC ED will change significantly as a result of this project,

B. The inpatient discharges and outpatient visits at FWMC, representing the zip code areas from which 75% of the discharges and outpatient visits were derived, are shown below:

Zip Code	Location	FWMC IP Disharges	% of FWMC Total IP Discharges	Cumulative % of FWMC Total IP Discharges	Maryland Total IP Discharges	FWMC Market Share
20744	Maryland	759	35.7%	35.7%	3,287	23.1%
20745	Maryland	321	15.1%	50.8%	2,038	15.8%
20748	Maryland	172	8.1%	58.9%	2,957	5.8%
20607	Maryland	112	5.3%	64.2%	641	17.5%
20735	Maryland	58	2.7%	66.9%	2,307	2.5%
20746	Maryland	55	2.6%	69.5%	705	7.8%
20032	District of Columbia	83	3.9%	73.4%	3,720	2.2%
20020	District of Columbia	49	2.3%	75.7%	762	6.4%
20747	Maryland	49	2.3%	78.0%	3,325	1.5%
Subtotal -- PSA		1,658	78.0%		19,742	8.4%
All Other Zips		468	22.0%			
Total FWMC IP Discharges		2,126	100.0%			

Source: HSCRC Inpatient Data Tape for year ending June 30, 2012

Note: Includes Psychiatric, OB/Newborn, Tertiary and Trauma Services

Zip Code	Location	FWMC ED Visits	% of FWMC Total ED Visits	Cumulative % of FWMC Total ED Visits	Maryland Total OP ED Visits	FWMC Market Share
20744	Maryland	13,730	31.0%	31.0%	18,683	73.5%
20745	Maryland	5,886	13.3%	44.3%	9,292	63.3%
20748	Maryland	3,678	8.3%	52.6%	12,021	30.6%
20607	Maryland	2,179	4.9%	57.5%	3,254	67.0%
20032	District of Columbia	1,984	4.5%	62.0%	4,129	48.1%
20735	Maryland	1,854	4.2%	66.2%	11,572	16.0%
20746	Maryland	1,459	3.3%	69.5%	9,307	15.7%
20020	District of Columbia	1,452	3.3%	72.7%	4,790	30.3%
20747	Maryland	1,392	3.1%	75.9%	12,997	10.7%
Subtotal -- PSA		33,614	75.9%		86,045	39.1%
All Other Zips		10,688	24.1%			
Total FWMC ED Visits		44,302	100.0%			

Source: HSCRC Outpatient Data Tape for year ending June 30, 2012

Note: Outpatient ED visits were used to define FWMC's Service area because currently a significant portion of inpatient admissions are transferred. The ED visits are more representative of FWMC's service area

C. In our view, the ACEP guidelines ideally contemplate the construction of a new hospital Emergency Department, and in situations where conditions permit, the expansion or replacement of an existing hospital's Department. Unfortunately, the conditions of FWMC's campus do not permit its current or expanded Emergency Department to reach the recommended minimum guidelines for Emergency Department square footage at current or projected volumes.

The FWMC Emergency Department expansion plan was designed to provide the greatest amount of useable additional patient care space within the budgetary and "footprint" constraints of its existing Department, the layout and location of the existing FWMC facilities, and the buildable acreage of the existing campus. FWMC acknowledges that the current volumes, the Department is "undersized" in comparison to the ACEP guidelines, and has done its best to improve patient access and throughput in its proposed expansion,in the spirit of the ACEP guidelines by adding additional square footage to the hospital facility adjacent to the existing Emergency Department. In addition, we have also forecast a reduction in ED visit volumes consistent with the impact of the physician recruitment plan for primary care physicians for the service area. The objective of the project is to come as close as practicable to reach the ACEP guidelines under significant physical and design constraints.

As shown on the project drawings, the small, two-story addition in this CON Application will expand the square footage of the FWMC Emergency Department in its proposed location. A sufficiently larger Department to meet the ACEP guidelines would have required the construction of a significantly larger and more expensive building, in another campus location, an alternative that was proposed by FWMC and CON-approved by the Commission in 2006. Unfortunately, that project was abandoned as a result of the decision by the State Highway Administration to create a highway right-of-way adjacent to the CON-approved construction site, making that larger project infeasible.

According to our estimates, there are approximately 4,130 DGSF of existing hospital spaces located outside the Department whose primary function is to support the FWMC Emergency Department, and would therefore be typically included in space allocated to the Emergency Department for purposes of comparisons to other hospitals and the ACEP guidelines. These spaces include: Two thirds of the Hospital's waiting, reception, registration and public toilets (2,730 DGSF), Medical Director's Office (120 DGSF), One half of the Hospital's imaging department space (1,120 DGSF), and the EMS room with toilet (160 DGSF).

Other Review Criterion

Need

MSGA Beds

15. Regarding the projected admissions and ALOS in Table 1 (in Attachment 6), please provide the following clarifications and additional information:

    A. A detailed description of how you arrived at the projected admissions in Table 1 (in Attachment 6) showing all calculations. The details should show the relationship between the population trends cited in number 10 and the utilization trends cited in number 11 in the explanatory notes on page 1 of Attachment 6. The details should include the following:
       i. use rates by age cohort for service area zip codes;
       ii. population by age cohort for service area zip codes; and
       iii. admissions and market share data by completing the table immediately below for service area zip codes.

    B. Explanatory note #14 in Attachment 6 alluded to "an increasing ALOS attributed to the change in case-mix related to the changes in MSGA admissions patterns to the hospital" and that "these changes ...are related to the successful implementation of the FWMC physician recruitment plan between 2013 and 2018."
       i. Please elaborate in more detail about the expected impact and assumptions attributed to: (1) primary care recruits and (2) surgical recruits.
       ii. What is the current number of general surgery and orthopedic FTEs practicing at FWMC?
       iii. What types of surgical cases are expected to increase as a result of the planned recruitment of 1.5 general and 2.0 orthopedic surgeons?

FWMC Response:

A. There is no numerical relationship that distinguishes between the projected admissions to FWMC shown in TABLE 1 and the overall hospital utilization and demographic trends of the residents of the FWMC service area.

   As stated in Attachment 6, the declines in MSGA utilization among residents of the FWMC service area is well-documented, and these declines were cited in the projected average annual decline of 3.5% per year between 2013 through 2019.

B. Because FWMC intends to change the number and mix of both its inpatients and outpatients between 2014 and 2019, based on the successful implementation of the physician recruitment plan, the historical trends of both the hospital and the service area population were not used to exclusively to calculate and project the FWMC MSGA admissions shown on TABLE 1. For example, as shown at Attachment D, there are 578 potentially avoidable MSGA cases identified by the HSCRC are projected to be reduced among all future patients using FWMC. Among all residents of the

FWMC service area, there is no practical way to project the reduction in potentially avoidable MSGA cases at other hospitals based on the HSCRC data alone.

FWMC is in the process of addressing the composition and size of its medical staff, because much of the change in the utilization of the Hospital over the past three years is the result of changes in physician utilization patterns at FWMC, both positive and negative. We anticipate these changes in utilization at FWMC to be significantly altered over the next five years, as the hospital successfully recruits additional primary care and specialty physicians. The impact of this recruitment is anticipated to increase utilization in some clinical services, e.g., inpatient and outpatient surgery, and decrease utilization in others, e.g., potentially avoidable admissions. It should also be noted that a more complete analysis would include the utilization of District of Columbia hospitals, for which complete and comparable data to Maryland hospitals for the entire three year period was not available when the application was prepared and submitted for review.

As shown below, the MSGA discharge rates to all Maryland hospitals have declined year-to-year over the 2011-2013 period; MSGA discharge rates to FWMC have declined, then increased. Hence, the specific characteristics of FWMC's utilization trends are not completely aligned with the trends reported at all Maryland hospitals for the service area residents. At least part of the explanation for this mis-alignment is the fact that FWMC is a very small hospital, with a very small market share among Maryland hospitals, particularly its immediate neighbor, Medstar Southern Maryland Hospital Center. Large changes in utilization are highly correlated to changes in physician practice patterns among the small number of physicians practicing at FWMC.

MSGA Use Rate
All Maryland Hospitals

	Population								
	15-64			65+			Total		
Zip Code	2011	2012	2013	2011	2012	2013	2011	2012	2013
20020	33,449	33,836	34,223	5,390	5,624	5,857	38,839	39,460	40,080
20032	24,859	25,148	25,437	3,079	3,240	3,402	27,938	28,388	28,839
20607	7,088	7,209	7,331	986	1,061	1,138	8,074	8,270	8,469
20735	25,266	25,296	25,325	4,381	4,636	4,891	29,647	29,932	30,216
20744	35,797	35,839	35,881	7,181	7,548	7,915	42,978	43,387	43,796
20745	20,256	20,177	20,097	2,918	3,088	3,257	23,174	23,265	23,354
20746	20,241	20,203	20,167	2,906	3,041	3,177	23,147	23,244	23,344
20747	27,977	27,898	27,818	3,445	3,650	3,857	31,422	31,548	31,675
20748	25,606	25,416	25,227	4,682	4,869	5,058	30,288	30,285	30,285
Total	220,539	221,022	221,506	34,968	36,757	38,552	255,507	257,779	260,058

	MSGA Discharges								
	15-64			65+			Total		
Zip Code	2011	2012	2013	2011	2012	2013	2011	2012	2013
20020	475	423	458	186	168	168	661	591	626
20032	360	334	277	102	99	117	462	433	394
20607	290	262	237	171	144	192	461	406	429
20735	1,453	1,396	1,333	1,555	1,484	1,377	3,008	2,880	2,710
20744	1,317	1,145	1,134	1,241	1,273	1,330	2,558	2,418	2,464
20745	940	875	748	498	500	424	1,438	1,375	1,172
20746	960	947	911	591	623	498	1,551	1,570	1,409
20747	1,687	1,434	1,367	881	825	780	2,568	2,259	2,147
20748	1,264	1,191	1,110	973	899	877	2,237	2,090	1,987
Total	8,746	8,007	7,575	6,198	6,015	5,763	14,944	14,022	13,338

	Use Rate (per 1,000 Population)								
	15-64			65+			Total		
Zip Code	2011	2012	2013	2011	2012	2013	2011	2012	2013
20020	14.20	12.50	13.38	34.51	29.87	28.68	17.02	14.98	15.62
20032	14.48	13.28	10.89	33.13	30.56	34.39	16.54	15.25	13.66
20607	40.91	36.34	32.33	173.43	135.72	168.72	57.10	49.09	50.66
20735	57.51	55.19	52.64	354.94	320.10	281.54	101.46	96.22	89.69
20744	36.79	31.95	31.60	172.82	168.65	168.04	59.52	55.73	56.26
20745	46.41	43.37	37.22	170.66	161.92	130.18	62.05	59.10	50.18
20746	47.43	46.87	45.17	203.37	204.87	156.75	67.01	67.54	60.36
20747	60.30	51.40	49.14	255.73	226.03	202.23	81.73	71.61	67.78
20748	49.36	46.86	44.00	207.82	184.64	173.39	73.86	69.01	65.61
Total	39.66	36.23	34.20	177.25	163.64	149.49	58.49	54.40	51.29

MSGA Use Rate
FWMC Only

	Population								
	15-64			65+			Total		
Zip Code	2011	2012	2013	2011	2012	2013	2011	2012	2013
20020	33,449	33,836	34,223	5,390	5,624	5,857	38,839	39,460	40,080
20032	24,859	25,148	25,437	3,079	3,240	3,402	27,938	28,388	28,839
20607	7,088	7,209	7,331	986	1,061	1,138	8,074	8,270	8,469
20735	25,266	25,296	25,325	4,381	4,636	4,891	29,647	29,932	30,216
20744	35,797	35,839	35,881	7,181	7,548	7,915	42,978	43,387	43,796
20745	20,256	20,177	20,097	2,918	3,088	3,257	23,174	23,265	23,354
20746	20,241	20,203	20,167	2,906	3,041	3,177	23,147	23,244	23,344
20747	27,977	27,898	27,818	3,445	3,650	3,857	31,422	31,548	31,675
20748	25,606	25,416	25,227	4,682	4,869	5,058	30,288	30,285	30,285
Total	220,539	221,022	221,506	34,968	36,757	38,552	255,507	257,779	260,058

	MSGA Discharges								
	15-64			65+			Total		
Zip Code	2011	2012	2013	2011	2012	2013	2011	2012	2013
20020	33	42	41	13	7	12	46	49	53
20032	45	36	47	28	20	25	73	56	72
20607	67	40	55	60	50	67	127	90	122
20735	52	34	40	40	41	53	92	75	93
20744	362	325	326	445	429	498	807	754	824
20745	207	175	202	134	132	136	341	307	338
20746	28	29	29	35	23	18	63	52	47
20747	37	36	39	13	25	15	50	61	54
20748	90	89	90	74	71	90	164	160	180
Total	921	806	869	842	798	914	1,763	1,604	1,783

	Use Rate (per 1,000 Population)								
	15-64			65+			Total		
Zip Code	2011	2012	2013	2011	2012	2013	2011	2012	2013
20020	0.99	1.24	1.20	2.41	1.24	2.05	1.18	1.24	1.32
20032	1.81	1.43	1.85	9.09	6.17	7.35	2.61	1.97	2.50
20607	9.45	5.55	7.50	60.85	47.13	58.88	15.73	10.88	14.41
20735	2.06	1.34	1.58	9.13	8.84	10.84	3.10	2.51	3.08
20744	10.11	9.07	9.09	61.97	56.84	62.92	18.78	17.38	18.81
20745	10.22	8.67	10.05	45.92	42.75	41.76	14.71	13.20	14.47
20746	1.38	1.44	1.44	12.04	7.56	5.67	2.72	2.24	2.01
20747	1.32	1.29	1.40	3.77	6.85	3.89	1.59	1.93	1.70
20748	3.51	3.50	3.57	15.81	14.58	17.79	5.41	5.28	5.94
Total	4.18	3.65	3.92	24.08	21.71	23.71	6.90	6.22	6.86

iii.

Market Share by Zip Code

	FWMC Discharges			Maryland Hospital Total Discharges			FWMC Market Share			FWMC Market Rank			
Zip Code	2011	2012	2013	2011	2012	2013	2011	2012	2013	2011	2012	2013	2013 Market Share Leader
20020	46	49	53	661	591	626	7.0%	8.3%	8.5%	6	5	6	SOUTHERN MARYLAND HOSPITAL
20032	73	56	72	462	433	394	15.8%	12.9%	18.3%	2	3	2	SOUTHERN MARYLAND HOSPITAL
20607	127	90	122	461	406	429	27.5%	22.2%	28.4%	2	2	2	SOUTHERN MARYLAND HOSPITAL
20735	92	75	93	3,008	2,880	2,710	3.1%	2.6%	3.4%	3	4	3	SOUTHERN MARYLAND HOSPITAL
20744	807	754	824	2,558	2,418	2,464	31.5%	31.2%	33.4%	2	2	2	SOUTHERN MARYLAND HOSPITAL
20745	341	307	338	1,438	1,375	1,172	23.7%	22.3%	28.8%	2	2	2	SOUTHERN MARYLAND HOSPITAL
20746	63	52	47	1,551	1,570	1,409	4.1%	3.3%	3.3%	5	5	5	SOUTHERN MARYLAND HOSPITAL
20747	50	61	54	2,568	2,259	2,147	1.9%	2.7%	2.5%	6	5	6	SOUTHERN MARYLAND HOSPITAL
20748	164	160	180	2,237	2,090	1,987	7.3%	7.7%	9.1%	2	2	2	SOUTHERN MARYLAND HOSPITAL
Grand Total	1,763	1,604	1,783	14,944	14,022	13,338	11.8%	11.4%	13.4%				

The impact of the physician recruitment plan on additional admissions to FWMC is shown on the chart located in Attachment 6, #13 to the Application filed on September 5, 2014. That chart was derived from the product line analysis shown below, indicating the projected number of additional discharges and ALOS by year at FWMC between 2014 and 2019.[2] Most of the growth in admissions to FWMC shown below is attributable to the planned physician recruitment in general surgery and orthopedics. Very little growth in FWMC admissions is attributable to primary care physician recruitment.

[2] For the projection for 2014, four additional discharges were "unclassified" and were not included in the product line total.

Impact of Recruiting Physicians
Cases, CMAD and Days

			Additional Discharges						Additional Case Mix Adjusted Discharges						Additional Days					
Product Line	CMI	ALOS	2014	2015	2016	2017	2018	2019	2014	2015	2016	2017	2018	2019	2014	2015	2016	2017	2018	2019
ABDOMINAL SURGERY	1.124	3.628	1	1	1	1	1	1	1	1	1	1	1	1	4	4	4	4	4	4
ABORTION	0.520	1.500	0	0	0	0	0	0	0	0	0	0	0	0	-	-	-	-	-	-
ALCOHOL/CHEMICAL DEPEND	0.507	5.923	0	0	0	0	0	0	0	0	0	0	0	0	-	-	-	-	-	-
CARDIOLOGY	0.655	3.010	4	4	4	4	4	4	3	3	3	3	3	2	12	12	12	12	12	11
COLON & RECTAL SURGERY	1.916	6.500	0	0	0	0	0	0	0.0	0.0	0.0	0.0	0.0	0.0	-	-	-	-	-	-
DERMATOLOGY	0.466	2.400	0	0	0	0	0	0	0.0	0.0	0.0	0.0	0.0	0.0	-	-	-	-	-	-
ENDO/METAB (MEDICAL)	0.704	4.654	2	1	1	1	1	1	1.4	0.7	0.7	0.7	0.7	0.7	9	5	5	5	5	5
ENDO/METAB (SURGICAL)	1.267	5.625	0	0	0	0	0	0	0.0	0.0	0.0	0.0	0.0	0.0	-	-	-	-	-	-
GASTROENTEROLOGY	0.587	2.919	3	2	2	2	3	3	1.8	1.2	1.2	1.2	1.8	1.8	9	6	6	6	9	9
GENERAL MEDICINE	1.037	4.602	2	1	1	1	1	1	2.1	1.0	1.0	1.0	1.0	1.0	9	5	5	5	5	5
GENERAL SURGERY	2.445	7.462	0	3	6	16	21	22	0.0	7.3	14.7	39.1	51.3	52.6	-	22	45	119	157	160
GYNECOLOGY	0.726	2.000	1	0	0	0	0	0	0.7	0.0	0.0	0.0	0.0	0.0	2	-	-	-	-	-
NEPHROLOGY	0.764	3.776	1	0	1	1	1	1	0.8	0.0	0.8	0.8	0.8	0.8	4	-	4	4	4	4
NEUROLOGY	0.683	2.877	3	4	5	6	6	7	2.0	2.7	3.4	4.1	4.1	4.4	9	12	14	17	17	19
NEUROSURGERY	1.632	4.500	0	0	0	0	0	0	0.0	0.0	0.0	0.0	0.0	0.0	-	-	-	-	-	-
OBSTETRICS	0.684	1.769	0	0	0	0	0	0	0.0	0.0	0.0	0.0	0.0	0.0	-	-	-	-	-	-
ONCOLOGY (MEDICAL)	0.735	3.806	1	1	1	1	1	1	0.7	0.7	0.7	0.7	0.7	0.7	4	4	4	4	4	4
ONCOLOGY (SURGICAL)	1.308	2.417	0	0	0	0	0	0	0.0	0.0	0.0	0.0	0.0	0.0	-	-	-	-	-	-
OPHTHALMOLOGY	0.746	3.000	0	0	0	0	0	0	0.0	0.0	0.0	0.0	0.0	0.0	-	-	-	-	-	-
ORAL SURGERY	0.507	2.000	0	0	0	0	0	0	0.0	0.0	0.0	0.0	0.0	0.0	-	-	-	-	-	-
ORTHOPEDICS	1.453	3.328	1	1	12	18	20	20	1.5	1.5	17.4	26.1	29.1	29.1	3	3	40	60	67	67
OTOLARYNGOLOGY	0.503	2.400	0	0	0	1	2	3	0.0	0.0	0.0	0.5	1.0	1.3	-	-	-	2	5	6
PLASTIC SURGERY	1.448	55.222	0	0	0	0	0	0	0.0	0.0	0.0	0.0	0.0	0.0	-	-	-	-	-	-
PSYCHIATRY	0.764	4.636	0	0	0	0	0	0	0.0	0.0	0.0	0.0	0.0	0.0	-	-	-	-	-	-
PULMONARY MEDICINE	1.062	4.844	3	1	0	0	0	0	3.2	1.1	0.0	0.0	0.0	0.0	15	5	-	-	-	-
UROLOGY	0.639	2.419	0	0	0	0	0	0	0.0	0.0	0.0	0.0	0.0	0.0	-	-	-	-	-	-
VASCULAR SURGERY	1.782	8.000	0	0	0	0	0	0	0.0	0.0	0.0	0.0	0.0	0.0	-	-	-	-	-	-
Totals	0.000	3.953	22	19	34	52	61	62	17.9	20.0	43.7	78.0	94.2	95.7	79	77	137	237	287	291
Average Length of Stay For Additional Discharges															3.59	4.03	4.04	4.56	4.70	4.70

Source: HSCRC Medical Record Information

Since the retirement of Dr. Samir Azer, an orthopedic surgeon, in 2013, there has been a decline in orthopedic cases at FWMC. The medical staff is voluntary. Nevertheless, in 2014, two new orthopedic surgeons joined the medical staff, and Hospital management anticipates finalizing an agreement with a general surgeon to join the medical staff by the second quarter of 2015.

The types of surgical cases that are expected to increase as a result of the planned recruitment of general and orthopedic surgeons at FWMC are shown on the chart above, for the orthopedics and general surgery product lines.

16. Provide a detailed explanation of the need for the six bed observation unit. Include information on the fluctuation of the census of observation patients (total of 1,892 days in 2013 reported on the Table 1). Such detail should show the fluctuation in daily census. This explanation should address any expected continuation of the use of beds on the MSGA unit for observation stays.

FWMC Response:

The volume of outpatient observation visits at FWMC is related to the volume of outpatient Emergency Department visits. Despite the fact that observation visits are considered an outpatient service, many hospitals, including Fort Washington, routinely care for these patients on inpatient nursing units when patient rooms in those units are unoccupied by inpatients and therefore available for outpatients.

Due to the decreasing inpatient census at FWMC over the past two years, some observation patients have been transferred from the FWMC Emergency Department to its second floor nursing unit when a patient room there is not occupied by an inpatient. Other observation outpatients remain in the FWMC Emergency Department until they are either admitted, transferred or sent home. The summary statistics on observation patients and visits were provided in the Application submitted on September 5, 2014. Historically, the day-to-day census counts of observation patients at FWMC have varied significantly based on the number of patients presenting at the Emergency Department.

As shown at Attachment E, the daily census of observation outpatients in CY 2013 has fluctuated from a low of 2 patients to a high of 13 patients, with an average of 6.5 patients/day, most of whom are seen in the MSGA nursing unit.

The project includes the establishment of a dedicated outpatient observation unit to be located in the expanded Emergency Department that has the capacity for six patients. In our view, this unit will not be sufficient to address the needs of observation patients projected for FWMC in the future, and therefore, we have proposed that unoccupied patient rooms in the current FWMC nursing unit continue to be available and used by outpatient observation patients through 2019, depending upon the daily patient needs and room availability as discussed above.

Operating Rooms

17. Please explain and quantify how FWMC expects each of the following factors described on pages 54 and 55 to contribute to the volume projections for inpatient and outpatient surgeries submitted on October 2, 2014 as page 55b:
    - Expected decrease in the number of patients transferred to other hospitals;
    - The number of physicians recruited; and
    - The willingness of the members of the medical staff who perform surgery at FWMC to perform more procedure at FWMC after project completion.

FWMC Response:

The development of the projections for surgical services were driven primarily by planned recruitment and physician retirements. Increases are associated projected recruitments while decreases are driven by retirements. See the response to Question 19. below for the outpatient surgery projections, and the response to Question 15.B.i. above for the inpatient surgery projections.

18. Submit data on the retirement of members of FWMC's medical staff during FY 2014 to date and the recruitment of new physicians over the same period. Quantify the impact of these changes on hospital admissions and surgical volume, both inpatient and outpatient.

FWMC Response:

	Projected	Historical Volumes		
	2014	2013	2012	2011
Orthopedics				
Retirement (Azer)	-	8,815	10,035	14,110
Replacement (Kholsa)*	15,470	10,165	11,375	11,360
Bhatnagar**	-	-	-	-
Vora**	-	-	-	-
Urology				
Retirement - Barakat	-	9,300	12,650	11,095
Khawandi	1,900	-	-	-
* Recruited by Azer as his replacement. Purchased ownership of the practice in 2013				
** Newly credentialed orthopedic surgeons at Fort Washington. Bhatnagar credentialed effective October 1, 2014 and Vora effective December 1, 2014				

19. Regarding Chart 9 on page 55b, please provide the following clarifications:

A. Please explain why inpatient surgical cases have been declining at FWMC over the past few years.
B. Please explain why the clean up minutes per case for outpatient surgery in 2011 was only 11 minutes when in 2012 and 2013 it was 30 minutes.
C. Please explain and justify why a 30 minute turnaround time is appropriate for FWMC.
D. Please specify and justify the assumptions that produced the projected increases in minutes per case as follows:
   - An increase in the average inpatient surgical minutes per case from 87 in 2013 to 120 minutes per case in 2019, an increase of approximately 38%.
   - An increase in the average outpatient surgical minutes per case from 53 minutes per case in 2013 to 76 minutes per case in 2019, an increase of 43.4%.

FWMC Response:

A. Declines for inpatient surgeries are similar to the general declines in volume in the hospital. Discussions with surgeons that frequently use Fort Washington state that the volume of surgical cases that they are seeing in their offices have been lower. Some of the physicians are aging and their practices are in decline. One of the orthopedic surgeons who did a significant volume of his cases at Fort Washington suffered an injury that ultimately led to his retirement at the end of 2013.

B. The chart for clean up minutes has been revised based on discussion with the Director of Perioperative Services. The Certificate of Need submission from 2012 estimated cleanup minutes at 30 minutes per case. The attached schedule includes clean up minutes at 15 minutes per inpatient case and 10 minutes per outpatient case.

C. See the response to B above.

D. Please see revised chart. The current averages for inpatient and outpatient cases are 101 minutes per inpatient case and approximately 60 minutes per outpatient case. As orthopedic cases increase as projected, there would be a slight increase in the average time for the inpatient cases.

Fort Washingont Medical Center
Summary of Historical Surgical Minutes

Year	Total Inpatient Surgical Cases	Total Inpatient Minutes	Cleanup Minutes	Total Minutes	Clean-Up Minutes/ Case	Total Minutes/ Case
2011	773	92,102	11,595	103,697	15	134.15
2012	699	58,510	10,485	68,995	15	98.71
2013	628	54,552	9,420	63,972	15	101.87
Projected			-	-		
2014	532	54,405	7,976	62,380	15	117.32
2015	555	56,905	8,321	65,225	15	117.58
2016	600	61,905	8,996	70,900	15	118.22
2017	668	69,405	10,016	79,420	15	118.94
2018	743	79,405	11,141	90,545	15	121.91
2019	772	81,878	11,587	93,465	15	121.00

Year	Total Outpatient Surgical Cases	Total Outpatient Minutes	Cleanup Minutes	Total Minutes		
2011	2,070	108,998	20,700	129,698	10	62.66
2012	2,381	126,466	23,810	150,276	10	63.11
2013	2,132	112,672	21,320	133,992	10	62.85
Projected						
2014	1,945	116,710	19,452	136,162	10	70.00
2015	2,084	125,040	20,840	145,880	10	70.00
2016	2,095	125,700	20,950	146,650	10	70.00
2017	2,139	128,340	21,390	149,730	10	70.00
2018	2,176	130,560	21,760	152,320	10	70.00
2019	2,213	132,780	22,130	154,910	10	70.00

Availability of More Cost-Effective Alternatives

20. Please compare the cost effectiveness of meeting the needs of the service area population through the proposed project with the cost effectiveness of providing each of the services at alternative existing facilities, especially the MSGA, Inpatient Surgery, and ED services.

FWMC Response:

The continued cost-effectiveness of FWMC is dependent upon the successful implementation of the project. Among the most important measures of the project's cost-effectiveness are:

1. The ability to provide inpatient and outpatient care in a facility that addresses FWMC current deficit of clinical and support space;
2. The ability to build a medical staff that will increase the availability of both primary care and specialty physicians to residents of the FWMC service area;
3. The ability of FWMC to respond to the objectives of the Maryland All-Payor Hospital System Modernization through nominal increases in volumes;
4. The ability to implement the project within the terms of the GBR with the HSCRC, as adjusted for population growth and aging.

FWMC does not intend to provide any new services or request additional rates as a result of implementing this project; its request is fundamentally to provide additional space to the caregivers and patients at FWMC, in terms of an expanded Emergency Department, additional private patient rooms, expanded surgery, and enlarged support space. The physician recruitment plan will provide opportunities for patients who have historically relied upon the FWMC ED for outpatient care to find a more cost-effective medical home in the community to obtain primary care services. It is generally considered more cost-effective for urgent primary care services to be provided in a private office or non-hospital setting as opposed to a hospital Emergency Department. Therefore, following the improvements of the FWMC facility and services proposed in this CON Application, providing those same ED services at another alternative existing hospital facility is not considered as cost-effective.

For those patients who continue to require inpatient MSGA hospital services, including inpatient surgery, the expanded medical staff of FWMC will provide these services, resulting in a higher case mix/severity level, and increased revenues for FWMC consistent with its GBR Agreement with the HSCRC. The physician recruitment plan will nominally increase the utilization of inpatient and outpatient surgical services at FWMC to partially offset the projected volume declines in avoidable ED visits and admissions. This shift in hospital utilization and service intensity together with the plan to address the shortage of primary care physicians is an important measure of the project's and FWMC's future effectiveness. Providing the improved facilities for these services is considered a more cost-effective alternative than providing these MSGA hospital services, including inpatient and outpatient

surgery, at another hospital, because the hospital's improved effectiveness will not be reflected in higher rates at FWMC, or lower rates at other hospitals.

On the cost side of the cost-effectiveness equation, FWMC has not included any rate or revenue increase to fund the proposed project in the projections for this CON, and it has made a GBR Agreement with the HSCRC which does not penalize FWMC for reducing re-admissions and potential avoidable admissions. The increase in projected income, as shown in the Hospital's revenue and expense projections, will help fund the recruitment of additional primary care physicians to the FWMC service area, as well as fund the capital costs of the project.

And because both Medstar Southern Maryland Hospital Center (MSMHC), the Maryland hospital with the largest MSGA market share among FWMC service area residents, and FWMC both have entered into GBR Agreements with the HSCRC which limit future revenue growth, the future cost of meeting the needs of the aging and growing FWMC service area population at SMHC instead of at FWMC are not anticipated to increase or decrease above those limits.

Comparisons of the cost effectiveness of hospitals located in the District of Columbia cannot be made because those hospitals' costs are not regulated by the HSCRC.

As noted above, the effectiveness of FWMC will be improved as a result of implementing this project, in comparison to other alternative existing facilities, and that improvement in FWMC's effectiveness will not require an increase in FWMC's rates in order to be financially viable. Therefore, within the limits of the GBR Agreements, the cost-effectiveness of providing services at alternative Maryland hospital facilities such as MSMHC is not comparable to the cost-effectiveness of providing those same services at FWMC.

Viability

21. Please provide a complete description of the funding plan for the project, documenting the availability of equity and sources of funds and demonstrating, to the extent possible, the ability of the applicant to obtain the debt financing proposed. Describe the State Grant for the ED, specifying when it was or will be approved and the time frame for implementation. Describe the alternative financing mechanisms considered in project planning and provide an explanation of why the proposed mix of funding sources was chosen.

FWMC Response:

As shown on page 12 of the updated application, Fort Washington will use $560,000 in designated cash on its balance sheet to match the $560,000 State Grant for the Emergency Department. Fort Washington currently has a taxable mortgage insured by the United States Department of Housing and Urban Development (HUD) through its Federal Housing Administration (FHA). The Hospital has maintained a very good working relationship with both HUD and its mortgage banker Oppenheimer throughout the period of the mortgage and completed a refinancing of this loan through the HUD 227A loan modification program in 2013. This was done to reduce the interest rate on the loan from 6.125% to 3.95%. Hospital's management has discussed the next phase of development on the campus with HUD and found them receptive to providing insurance on the new project under review by the MHCC. Having completed two financings through HUD, management is familiar with the steps to secure a mortgage through this process as well as the compliance items required to maintain the loan once the financing is complete.

The State Grant for the Emergency Department is a Maryland Hospital Association Bond Bill item originally approved in 2007 for design, planning, renovation, expansion, repair and construction of the Emergency Department at Fort Washington Medical Center. The grant now has an extended date that expires June 1, 2016.

Based on the size and financial position of Fort Washington, HUD was determined to be the best financing alternative.

22. Describe and document relevant community support for and opposition to the proposed project.

FWMC Response:

FWMC continues to have strong community support for its proposed project. Additional letters of support will be forwarded to the MHCC as they are received. See Attachment F.

23. Identify the performance requirements applicable to the proposed project and explain how the applicant will be able to implement the project in compliance with those performance requirements. Explain the process for completing the project design, contracting and obtaining and obligating the funds within the prescribed time frame. Describe the construction process or refer to a description elsewhere in the application that demonstrates that the project can be completed within the applicable time frame.

FWMC Response:

Because the project proposes a capital expenditure in excess of $5,000,000, the three applicable performance requirements are as follows:

COMAR 10.24.01.12:

1. There shall be an obligation of not less than 51 percent of the approved capital expenditure within 24 months of CON Approval, as documented by a binding construction contract or equipment purchase order;
2. The initiation of construction shall take place within 4 months of the effective date of a binding construction contract, and construction shall be continuous after that;
3. Up to 24 months after the effective date of a binding construction contract to complete the project.

Within six weeks of the CON-approval date, the construction contract bidding and award will be made.

One month after making the capital obligation, building permits will be obtained, site preparation will conclude and new construction will commence. Construction of the 2-story patient addition will be completed and occupied within 18 months of the capital obligation. The remainder of the new construction and renovations will be completed within another six months.

FWMC is fully confident that it can meet the applicable performance requirements following CON approval.

24. Regarding the financial tables provided in Attachment 6, please provide the following additional information and clarifications:

A. Regarding the projected revenue and expenses (Table 3), please provide the following clarifications:
   i) The response to question 11 indicates that the project will not be completed until 36 months after CON approval. Given that CON action is not likely until the end of the first quarter of 2015 at the earliest, explain why the revenue and expense projections (both with inflation and without) show project interest, depreciation, and amortization beginning in 2016. Revise the tables accordingly as necessary.
   ii) Given that the first Table 3 in Attachment 6 is presumably without inflation, explain why gross revenue per equivalent inpatient admission (EIA) and patient day (EIPD) and total operating expenses per EIA are projected to increase from 2013 to 2019. MHCC staff calculates the revenue to increase from $8,321 to 10,198 per EIA and from 2,325 to 2,577 per EIPD. Similarly, MHCC staff calculates that total operating expenses per EIA are projected to increase from $7,019 to $8,231. Revise the table accordingly as necessary.

B. For the Assumption page, provide the following clarifications and additional information:
   i) Explain what is included on the assessments line.
   ii) One of the notes states that bad debts are expected to decrease as a result of the expansion of Medicaid and the Affordable Care Act. Explain why charity care has not been projected to decline for the same reason.
   iii) Describe the expense efficiencies and savings improvements that have been projected for contracted services, equipment and other expenses ($175,000 in 2015 and $262,000 in 2016) and explain how they will be achieved.
   iv) What is included in the rent expense and why is no volume variability expected?

C. Regarded the GBR Revenue page, please provide the following clarifications and additional information:
   i) Detail the calculation of the population adjustment for each year identifying the source of all information used and showing the calculations.
   ii) Explain Slippage and Change in Markup and explain why they only occur in SFY 6/30/2015.
   iii) What are the one-time adjustments and why do they only appear in State Fiscal Years 2014 and 2015?

D. Submit an Assumption sheet and a Projection of GBR Revenue sheet for the inflated Table 3 including assumptions made in projecting the inflationary increases in the various expense lines.

FWMC Response:

A. i. and ii., Revised Table 3s, inflated and uninflated, corresponding to the updated implementation schedule, are found at Attachment I. As explained in response to Question 12, and shown in Attachment D, the case-mix index of FWMC MSGA Admissions is projected to increase from .7966 in 2014 to .8877 2019, which corresponds to the projected increase in gross revenue and expenses during those periods as you have noted in the question. The impact of recruitment of specialists physicans and surgeon the Hospital's case-mix, together

with the elimination of Potentially Avoidable Volumes, explains the projected increases in revenue and expenses per EIA and EIPD.

B. The assessments line includes amounts as pass-throughs from the HSCRC including Medicaid Deficit Funding (Board of Public Works Hospital and Payor Portion), the Hospital Provider Tax (Health Care Coverage Fund), Maryland Health Insured Partners (MHIP) and Nurse Support Program (Programs I and II). Only a minor decline in bad debt expense is reflected in FY 2014. The Hospital's alignment of charity care is based on appropriate identification of cases remains a constant at 3.6%. Bad debt is a constant at 8.71% offset by funding from the Uncompensated Care Fund at 5.78%.The savings and improvements driving savings projected for 2015 and 2016 relate to:

a. Services: The reduction of consulting cost for implementation of ICD10. The Hospital has been investing significant dollars in training and testing for the expected 2015 start date including a projected $200,000 in the 2013 baseline cost. In 2015, the need for consulting support will decline and will conclude in 2016. $100,000 in reductions each year.
b. Equipment – The hospital has already initiated plans to buyout an existing pharmacy equipment lease on Pyxis machines eliminating the operating cost ($75,000 in 2015 and $30,000 in 2016)
c. Legal and consulting fees associated with affiliation negotiations will decline by $132,000 in 2016

C. i) The GBR Revenue page is found at Attachment G, with notes that explain the adjustments for each year.

Calculation of Population Change
FWMC Service Area
2013-2018

Age Cohort	2013 Population	2018 Estimated Population	% Change
15-54	179,518	176,982	-1.41%
55-64	41,988	45,833	9.16%
65-74	24,834	31,792	28.02%
75-84	10,501	13,341	27.05%
85+	3,217	3,822	18.81%
Total	260,058	271,770	4.50%
Annual Population Change Age 15+			**0.88%**
Age 65+ Subtotal	38,552	48,955	26.98%
Annual Population Change Age 65+			**4.89%**

Source: Claritas

ii) Slippage is computed by the HSCRC; HSCRC has not computed or published an amount related to years beyond Rate Year 2015. Markup did not assume changes for Rate Year 2016 moving forward.

iii) See explanation above; no assumptions for Fiscal Year 2016 moving forward for overcharges or undercharges and did not assume any changes in MHAC/QBR scaling.

D. See Attachment G.

Impact on Existing Providers

25. The response to the Impact on Existing Providers review criterion does not include a response to the wording of the criterion, which requires the applicant to provide information and analysis with respect to the impact of the proposed project on existing health care providers in the service area. Please provide a quantitative analysis of why the significant improvements proposed for FWMC's physical plant will not affect the market shares in its service area in such a way as to impact MedStar Southern Maryland Hospital Center and other area hospitals.

FWMC Response:

As discussed at the meeting between FWMC representatives and MHCC staff on November 21, 2014, FWMC entered into a Global Budget Revenue (GBR) Agreement with the Maryland Health Services Cost Review Commission ("HSCRC") on July 16, 2014, in which increases and decreases in FWMC's regulated revenues are subject to potential future adjustments as specified in the Agreement.

Three such adjustment are: 1) the weighted population changes projected in FWMC's service area, 2) changes in inflation, and 3) verified changes in market share. Changes in service area's projected weighted population were incorporated into the volume and revenue projections provided in the CON Application for FWMC through FY 2019. These changes are largely the result of the rapidly growing and aging population of the service area, as shown in Response to Question 24 C.i. above.

In considering the impact of the proposed project on existing providers in the FWMC services area, one other Maryland hospital, Medstar Southern Maryland Hospital Center (MSMHC), could potentially be impacted by FWMC's proposed project, if revenue changes at either hospital were the result of changes in market share brought about by the project. In this application, we do not consider the changes in patient volumes at FWMC among residents of its service area through 2019 to be sufficiently large to have any measurable impact on MSMHC prospectively.

Because the projected growth in volumes and revenues at FWMC before and after project implementation were consistent with service area projected weighted population changes, for which FWMC revenues will be adjusted under its GBR Agreement, the projected market share changes between FWMC and other Maryland hospitals as a result of the project were not deemed to be necessary to demonstrate FWMC's financial feasibility. For that reason, we are confident that the impact of the project will have no impact on the market shares of FWMC or MSMHC in such a way as to negatively impact the future revenues of either hospital.

It should be noted that Medstar Health also entered into a GBR Agreement which includes MSMHC, and this agreement is subject to the same categories of revenue adjustments as FWMC's.

In our view, the terms of the GBR Agreements for both MSMHC and FWMC, completely eliminate any potential impact on MSMHC's revenues as a result of FWMC successfully implementing its proposed project.

The pertinent section of the GBR Agreements is shown below:

> The GBR model assures hospitals that adopt it that they will receive an agreed-on amount of revenue each year—i.e., the Hospital's "Approved Regulated Revenue" (Approved Regulated Revenue) under the GBR system-- regardless of the number of Maryland residents they treat and the amount of services they deliver provided that they meet their obligations to serve the health care needs of their communities in an efficient, high quality manner on an ongoing basis. The GBR model removes the financial incentives that have encouraged hospitals to increase their volume of services and discouraged them from reducing their levels of "Potentially Avoidable Utilization" (PAU) and marginal services. It provides hospitals with much-needed flexibility to use their agreed-on global budgets to effectively address the "Three Part Aim" objectives of better care for individuals, higher levels of overall population health, and improved health care affordability. (Page 3)

With the financial incentives to increase volumes and revenues removed from FWMC and MSMHC, both are likely to continue to serve their communities under revenue constraints specifically designed to achieve better care for individuals, higher levels of overall population health, and improved health care affordability.

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing responses to the MHCC staff questions (letter Riklin to Meacham, 10/24/2014) and its attachments regarding the docketed Certificate of Need Application (Docket No. 12-16-2334) are true and correct to the best of my knowledge, information, and belief.

Verna S. Meacham, President and CEO

12/11/2014
Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing responses to the MHCC staff questions (letter Riklin to Meacham, 10/24/2014) and its attachments regarding the docketed Certificate of Need Application (Docket No. 12-16-2334) are true and correct to the best of my knowledge, information, and belief.

Joseph B Tuke Sr. Vice President, Finance — 12/11/2014

Name and Title — Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing responses to the MHCC staff questions (letter Riklin to Meacham, 10/24/2014) and its attachments regarding the docketed Certificate of Need Application (Docket No. 12-16-2334) are true and correct to the best of my knowledge, information, and belief.

RT Coughlin
Name and Title

12/12/14
Date

ATTACHMENT A

Fort Washington Medical Center
Estimated Average Charges for Common Procedures

The tables below provide estimated average charges for common inpatient and outpatient procedures at Fort Washington Medical Center. These tables are updated quarterly and are based on the patient charges actually incurred for these services during the previous six months. These amounts may be used by patients to estimate the charge for services that they may incur.

Please note that these are only estimates and are subject to change without notice. The actual cost of your procedure may be higher or lower based on factors specific to your case, such as your length of stay in the hospital and the complexity of your medical condition. If you have questions regarding an estimated charge, please call a Financial Counselor at 301-203-2154.

These estimates reflect hospital charges only. They do not include physician or other provider fees that are billed separately from the hospital fees. You may receive bills from multiple physicians for their services, including but not limited to your anesthesiologist, hospitalist, pathologist, radiologist, cardiologist, emergency room physician, and other specialist who participate in your care. If you have questions regarding the bill for their services, please contact the individual provider.

INPATIENT SURGICAL CASES

MOST FREQUENT INPATIENT MEDICAL/SURGICAL CASES	Average Charge
392 ESOPHAGITIS GASTROENT & MISC DIGEST DISORDERS W/O MCC	$4,669.31
603 CELLULITIS W/O MCC	$5,704.21
812 RED BLOOD CELL DISORDERS W/O MCC	$7,430.49
641 MISC DISORDERS OF NUTR,METABOLISM,FLUIDS/ELECTOLYTES W/O MCC	$5,605.81
690 KIDNEY & URINARY TRACT INFECTIONS W/O MCC	$6,836.80
378 G.I. HEMORRHAGE W CC	$5,763.84
638 DIABETES W CC	$6,840.30
293 HEART FAILURE & SHOCK W/O CC/MCC	$6,789.87
313 CHEST PAIN	$4,688.29
192 CHRONIC OBSTRUCTIVE PULMONARY DISEASE W/O CC/MCC	$7,677.06

OUTPATIENT SURGICAL CASES

MOST FREQUENT OUTPATIENT SURGICAL CASES	Average Charge
1341 CATARAC PHACOEMULS ASPIR	$3,024.01
5123 LAPARASCOPIC CHOLECYSTECTOMY	$8,476.95
8521 LOCAL EXCIS BREAST LES	$4,245.41
806 EXCIS KNEE SEMILUN CARTL	$4,842.05
8147 OTHER REPAIR OF KNEE	$5,126.97
6909 D & C NEC	$4,075.17
8363 ROTATOR CUFF REPAIR	$7,062.53
1712 LAPRAOSCOPIC REPAIR OF INDIRECT ING	$8,904.33
8201 EXPLOR TEND SHEATH-HAND	$2,859.49
0443 CARPAL TUNNEL RELEASE	$3,240.81

LAB

Frequency	AverageCost
1082462 CHEM7 + CAL, (BMP)	$30.69
1082587 CHEM 12+CO2, (CMP)	$41.84
1082580 TROPONIN-I	$69.84
1089983 CPK	$16.76
1082460 LIPASE, BLOOD	$22.29
1082530 .URINALYSIS, MICROSCOP	$13.91
1082534 BETA HCG QUAL, URINE	$27.93
1080099 PT/INR	$22.32
1085070 CULTURE, URINE	$55.21
1086200 CHLAMYDIA TRACHOMATIS,	$125.30

Radiology

Frequency	AverageCost
5871010 XR CHEST SINGLE 1V	$71.24
5871020 XR CHEST PA/LAT 2V	$106.93
5876856 US PELVIS GENERAL	$457.56
5876830 US TRANSVAGINAL	$423.01
5873562 XR KNEE COMP/LT 4V	$106.57
5876700 US ABD COMP	$499.20
5873631 XR FOOT/RT 3V	$106.51
5873630 XR FOOT/LT 3V	$106.86
5873563 XR KNEE COMP/RT 4V	$106.98
5873611 XR ANKLE COMP/RT 4V	$106.65

Cat Scan

Frequency	AverageCost
6370450 CT HEAD WO CON	$285.44
6374176 CT ABD PELVIS WO CONTR	$272.11
6371275 CT ANGIO CHEST	$458.58
6374177 CT ABD PELVIS W CONTRA	$628.87
6372250 CT CERVICAL WO CON	$324.64
6370860 CT MAX/FACIAL WO CON	$123.95
6371500 CT THORAX WO CON	$320.60
6372310 CT LUMBAR WO CON	$346.43
6372920 CT PELVIS WO CON	$269.15
6370410 CT SOFT TIS/NECK W CON	$403.64

Nuclear Medicine

Frequency	AverageCost
6078582 NM LUNG VENTILATION AN	$1,997.66
6078452 NM MYOCARDIAL PERF IMA	$1,914.57
6078464 NM MYCRDL PRFSN IMG,SN	$1,913.05
6078230 NM DISIDA-HEPATOBIL DU	$1,052.76
6078349 NM BONE SCAN THREE PHA	$1,243.72
6078360 NM BONE SCAN TOTAL BOD	$1,057.16
6078800 NM LUNG SCAN PERFUSION	$1,034.33
6078780 NM ACUTE GI BLOOD LOSS	$1,413.65
6078823 NM LUNG VENTILATION AE	$1,198.59
6078365 NM BONE FLOW	$756.69

ATTACHMENT B

TITLE: FINANCIAL ASSISTANCE PLAN

PURPOSE:

The purpose of this policy is to document the Fort Washington Medical Center (FWMC) process for granting financial assistance where patients are unable to meet their obligations to the organization due to lack of insurance or other financial resources or other conditions of financial hardship.

POLICY:

Fort Washington Medical Center provides care to all patients regardless of ability to pay.

It is the policy of Fort Washington Medical Center to provide Financial Assistance based on inability to pay or high medical expenses for patients who meet specified financial criteria and request such assistance.

The determination of probable eligibility for Financial Assistance (or charity care services) will be made within two business days following a patient's request for such services, application for medical assistance or both.

FWMC will communicate the availability of financial assistance on the hospital website and in hospital publications.

A notice of FWMC's Financial Assistance Plan will be posted in the Admitting & Registration (Admissions) Department, Patient Accounts (Business Office), in the Emergency Department, and Administration.

Individual notice regarding the hospital's charity care policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital.

PROCEDURE:

1. Patient's will be informed of the following upon admission through the Financial Assistance Brochure/Information Sheet:
    a. Description of the Financial Assistance Policy;
    b. Patient's rights and obligations with regard to hospital billing and collection under the law;
    c. Contact information at the hospital that is available to assist the patient, the patient's family/significant other, or the patient's authorized representative in order to understand:
        i. The patient's hospital bill;
        ii. The patient's rights and obligations with regard to the hospital bill;
        iii. How to apply for free and reduced cost care in the billing office;
        iv. How to apply for the Maryland Medical Assistance Program and any other programs that may help pay the bill.

d. Contact information for the Maryland Medical Assistance Program;

e. Physician charges are not included in the hospital bill and are billed separately.

2. The patient's initial bill will include reference on whom to contact for Financial Assistance Information.

3. The Financial Assistance Brochure/Information sheet will be distributed to each patient.

4. An evaluation for Financial Assistance can be commenced in a number of ways:
   a. A patient with a self-pay balance due notifies the self-pay collector that he/she cannot afford to pay the bill and requests assistance.
   b. A patient presents at a clinical area without insurance and states that he/she cannot afford to pay the medical expenses associated with their current or previous medical services.
   c. A physician or other clinician refers a patient for financial assistance evaluation for potential admission.

5. The Insurance Verification Representative/Financial Counselor (located in the Admitting office), Admitting and Patient Accounts personnel will be responsible for taking Financial Assistance applications.

6. When a patient requests Financial Assistance, the staff member who receives the request will:
   a. AFTERHOURS/WEEKEND: Give the patient a Financial Assistance Program and Practices brochure and application (attached) and refer the patient to contact the Insurance Verification Representative/Financial Counselor. Patients may drop off applications with anyone in the Admitting area.
   b. DURING THE WORKWEEK NORMAL BUSINESS HOURS: Refer the patient to the Insurance Verification Representative/Financial Counselor.

7. To make a determination of **probable eligibility** for Financial Assistance, the applicant must complete the Maryland State Uniform Application for Financial Assistance.
   a. The Insurance Verification Representative/Financial Counselor will perform an assessment to determine if the patient meets preliminary criteria based on the family size/income as defined by Medicaid regulations (See Attached Poverty Level Guidelines Table).
   b. A Letter of Conditional Approval for probable eligibility (see attached) will be sent to the patient within two business days.
   c. The person seeking financial assistance may contact Insurance Verification at the end of the second business day to learn of the determination.
   d. Applications received and preliminary determinations made by the Insurance Verification Representative/Financial Counselor will be sent daily to Patient Accounts for review

8. In order to make the final determination for Financial Assistance as provided for in the letter of conditional approval, following documents must be provided to any personnel in Admitting or Patient Accounts.
   a. A copy of the conditional approval letter (attached).
   b. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income as defined by Medicaid regulations).
   c. A copy of the three (3) most recent pay stubs (if employed) or other evidence of income of any other person whose income is considered part of the family income as defined by Medicaid regulations.
   d. A Medical Assistance Notice of Determination (if applicable).
   e. Proof of disability income (if applicable).
   f. Reasonable proof of other declared expenses.

9. The following must be met in order for a review for a final determination for a Financial Assistance adjustment:
   a. The patient must apply for Medical Assistance unless the financial representative can readily determine that the patient would fail to meet the disability requirement. In cases where the patient has active Medicare Prescription Drug Program or Qualified Medicare Beneficiary (QMB) coverage, it would not be necessary to reapply for Medical Assistance unless the financial representative has reason to believe that the patient may be awarded full Medical Assistance benefits.
   b. Review viability of offering a payment plan agreement.
   c. All insurance benefits have been exhausted.

10. A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses. If the patient's application for Financial Assistance is determined to be complete and appropriate:
    a. the Insurance Verification Representative/Financial Counselor will forward all documents and recommended patient's level of eligibility to the Director, Patient Accounts;
    b. the Director of Patient Accounts has the authority to approve/reject charity amounts less than $5,000; and
    c. The Chief Financial Officer has the authority to approve/reject charity amounts estimated to exceed $5,000.

13. A Letter of Final Determination (see attached) will be sent to the patient within 30 days to inform him/her eligibility for:
    a. Financial Assistance (Full or partial)
    b. Payment Plan
14. FWMC has the option to designate certain elective procedures for which no Financial Assistance options will be given.

15. Once a patient is approved for Financial Assistance, it is expected that the patient will continue to meet his/her required financial commitments to Fort Washington Medical Center. If a patient is approved for a percentage allowance due to financial hardship and the patient does not make the required initial payment within 60 days towards their part of the bill, the Financial Assistance allowance will be reversed and the patient will owe the entire amount. It is recommended that the patient make a good faith payment at the beginning of the Financial Assistance period.
16. Any payment schedule developed through this policy will ordinarily not exceed two years in duration. In extraordinary circumstances, a payment schedule may extend to three years in duration, with the approval of the Chief Financial Officer.
17. The Director of Patient Accounts will advise ineligible patients of other alternatives available to them including Medical Assistance or bank loans.
18. Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This should include a review of the patient's existing (including any accounts having gone to bad debt within 3 months of application date) and any projected medical expenses.
19. A determination of Financial Assistance will be re-evaluated every six (6) months as necessary.

GLOSSARY

TERM	DEFINITION
Catastrophic circumstances	A situation in which the self-pay portion of the FWMC medical bill is greater than the patient/guarantor's ability to repay with current income and liquid assets in 24 months or less.
Current Medical Debt	Self-responsible portion of current inpatient and outpatient affiliate account(s). Depending on circumstances, accounts related to the same spell of illness may be combined for evaluation. Collection agency accounts are considered.
Liquid Assets	Cash/Bank Accounts, Certificates of Deposit, bonds, stocks, Cash Value life insurance policies, pension benefits.
Living Expenses	Per person allowance based on the Federal Poverty Guidelines times a factor of 3. Allowance will be updated annually when guidelines are published in the Federal Register.
Permanent Resident	Holder of a United States Permanent Resident Card, also known as a "green card," which is an identification process card attesting the permanent resident status of alien in the United States of America. The green card serves as proof that its holder, a Lawful Permanent Resident (LPR), has been officially granted immigration benefits, which include permission to conditionally reside and take employment in the USA. The holder must maintain his permanent resident status, and can be removed if certain conditions of such status are not met.
Projected Medical Expenses	Patient's significant, ongoing annual medical expenses, which are reasonably estimated, to remain as not covered by insurance carriers (i.e. drugs, co-pays, deductibles and durable medical equipment.)
Qualified Medicare Beneficiary (QMB)	The QMB program is for persons with limited resources whose incomes are at or below the national poverty level. It covers the cost of the Medicare premiums, coinsurance and deductibles that Medicare beneficiaries normally pay out of their own pockets.
Spell of Illness	Medical encounters/admissions for treatment of condition, disease, or illness in the same diagnosis-related group or closely related diagnostic-related group (DRG) occurring within a 120-day period.
Supporting Documentation	Pay stubs; W-2s; 1099s; workers' compensation, social security or disability award letters; bank or brokerage statements; tax returns; life insurance policies; real estate assessments; and, credit bureau reports.
Take Home Pay	Patient's and/or responsible party's wages, salaries, earnings, tips, interest, dividends, corporate distributions, net rental income before depreciation, retirement/pension income, social security benefits, and other income as defined by the Internal Revenue Service, after taxes and other deductions.

TRAINING:

All staff will be informed of the Financial Assistance Plan and their specific responsibilities related to this plan.

Training will be provided at orientation, annual professional update and periodically as indicated.

DOCUMENTATION:

Registrars will document that they provided the newly admitted patient with the Financial Assistance Brochure/Information Sheet in the information system by placing a check in the HIPAA box. This check indicates that HIPAA, Patient's Rights Brochure and the Financial Assistance Brochure was given to the patient.

ANNUAL EVALUATION:

FWMC Trends of Annual Percent of Financial Benefit
Update Poverty Table
Review of literature for national, state and local legislative review to maintain current compliance.

APPROVAL PROCESS/COMMITTEE FLOW:

Finance Committee
Patient Safety/Performance Improvement Committee (for information)
President and CEO

REFERENCE (S):

Federal Register (Poverty Level Guidelines)
Maryland legislation §19-214.1
Maryland State Uniform Financial Assistance Application located at www.hscrc.**state.md**.us/consumers_**uniform**.cfm
FWMC Patient Rights and Responsibilities brochure
HB 1069 HSCRC Financial Assistance and Debt Collection Policy (Effective 6/1/2009)

ATTACHMENT(S):

Financial Assistance Program and Practices brochure
Letter of Conditional Approval
Letter of Determination
Financial Assistance Notice for lobby
2012 Poverty Level Guidelines (January 2012 Federal Register)
Maryland State Uniform Financial Assistance Application

DATE REVIEWED:	SIGNATURE:	DATE REVIEWED:	SIGNATURE:

APPROVED: Verna S. Meacham, President/CEO	DATE ISSUED: 11/1998	DATE REVISED: 12/21/07, 6/2009, 4/2012 ,3/2013, 11/2014

Fort Washington Medical Center
11711 Livingston Road
Fort Washington, MD 20744

Maryland State Uniform Financial Assistance Application

FWMC

Information About You

Name _____
First Middle Last

Social Security Number ___-___-___ Marital Status: Single Married Separated
US Citizen: Yes No Permanent Resident: Yes No

Home Address _____ Phone _____

_____

_____ _____
City State Zip code Country

Employer Name _____ Phone _____

Work Address _____

_____
City State Zip code

Household members:

Name	Age	Relationship

Have you applied for Medical Assistance Yes No
If yes, what was the date you applied? _____
If yes, what was the determination? _____

Do you receive any type of state or county assistance? Yes No

Fort Washington Medical Center
11711 Livingston Road
Fort Washington, MD 20744

Maryland State Uniform Financial Assistance Application

FWMC

I. Family Income

List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals.

	Monthly Amount
Employment	
Retirement/pension benefits	
Social security benefits	
Public assistance benefits	
Disability benefits	
Unemployment benefits	
Veterans benefits	
Alimony	
Rental property income	
Strike benefits	
Military allotment	
Farm or self employment	
Other income source	
Total	

II. Liquid Assets

	Current Balance
Checking account	
Savings account	
Stocks, bonds, CD, or money market	
Other accounts	
Total	

III. Other Assets

If you own any of the following items, please list the type and approximate value.

Home	Loan Balance _____		Approximate value	_____
Automobile	Make _____	Year _____	Approximate value	_____
Additional vehicle	Make _____	Year _____	Approximate value	_____
Additional vehicle	Make _____	Year _____	Approximate value	_____
Other property			Approximate value	_____
		Total		_____

IV. Monthly Expenses

	Amount
Rent or Mortgage	
Utilities	
Car payment(s)	
Credit card(s)	
Car insurance	
Health insurance	
Other medical expenses	
Other expenses	
Total	

Do you have any other unpaid medical bills? Yes No

For what service? _____

If you have arranged a payment plan, what is the monthly payment? _____

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make a supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within ten days of the change.

_____ _____

Applicant signature Date

_____

Relationship to Patient

Please return this form to a Financial Counselor located in the Admitting Office.
If you have any questions, please call: 301-203-2271 or 2154.

Fort Washington Medical Center
11711 Livingston Road
Fort Washington, MD 20744

Maryland State Uniform Financial Assistance Application

FWMC

Please return this form to a Financial Counselor located in the Admitting Office.
If you have any questions, please call: 301-203-2271 or 2154.

Fort Washington Medical Center
11711 Livingston Road
Fort Washington, MD 20744

FINAL LETTER OF DETERMINATION FOR FINANCIAL ASSISTANCE

Date:

Dear Sir or Madam:

We have reviewed your MARYLAND STATE UNIFORM FINANCIAL APPLICATION. Based on the information provided, our final decision is that you qualify for:

- ☐ Financial Assistance
  - ☐ Full
  - ☐ Partial
- ☐ Payment Plan
- ☐ No Financial Assistance

We thank you for your patience during this review process. If we can be of further assistance, please feel free to call the Insurance Verification Representative/Financial Counselor at 301-203-2271 or 2154 or myself at 301-203-5401.

Sincerely,

Betty Edwards
Director, Patient Accounts

Fort Washington Medical Center
11711 Livingston Road
Fort Washington, MD 20744

LETTER OF CONDITIONAL APPROVAL FOR FINANCIAL ASSISTANCE

Date:

Dear Sir or Madam:

We have reviewed your MARYLAND STATE UNIFORM FINANCIAL ASSISTANCE APPLICATION. Based on the information provided, our preliminary decision is that you qualify for:

- ☐ Financial Assistance
  - ☐ Full
  - ☐ Partial
- ☐ Payment Plan
- ☐ No Financial Assistance

In order to make a final determination, please provide us with the following information:

- ☐ A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return, and a copy of any other person's tax return whose income is considered part of the family income as defined by Medicaid regulations).
- ☐ A copy of the three (3) most recent pay stubs (if employed) or other evidence of income of any other person whose income is considered part of the family income as defined by Medicaid regulations.
- ☐ A Medical Assistance Notice of Determination (if applicable).
- ☐ Proof of US citizenship or permanent residence status.
- ☐ Proof of disability income (if applicable).
- ☐ Reasonable proof of other declared expenses.
- ☐ No other information is necessary at this time.
- ☐

You will be notified within thirty days of our final determination. We thank you for your patience. If you have any questions or if we can be of further assistance, please feel free to call the Insurance Verification Representative/Financial Counselor at 301-203-2271 or 2154 or myself at 301-203-5401.

Sincerely,

Betty Edwards
Director, Patient Accounts

2014 POVERTY GUIDELINES

ALL STATES (EXCEPT ALASKA AND HAWAII) AND D.C.

ANNUAL GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY GUIDELINE								
	100%	120%	133%	135%	150%	175%	185%	200%	250%
1	11,670.00	14,004.00	15,521.10	15,754.50	17,505.00	20,422.50	21,589.50	23,340.00	29,175.00
2	15,730.00	18,876.00	20,920.90	21,235.50	23,595.00	27,527.50	29,100.50	31,460.00	39,325.00
3	19,790.00	23,748.00	26,320.70	26,716.50	29,685.00	34,632.50	36,611.50	39,580.00	49,475.00
4	23,850.00	28,620.00	31,720.50	32,197.50	35,775.00	41,737.50	44,122.50	47,700.00	59,625.00
5	27,910.00	33,492.00	37,120.30	37,678.50	41,865.00	48,842.50	51,633.50	55,820.00	69,775.00
6	31,970.00	38,364.00	42,520.10	43,159.50	47,955.00	55,947.50	59,144.50	63,940.00	79,925.00
7	36,030.00	43,236.00	47,919.90	48,640.50	54,045.00	63,052.50	66,655.50	72,060.00	90,075.00
8	40,090.00	48,108.00	53,319.70	54,121.50	60,135.00	70,157.50	74,166.50	80,180.00	100,225.00

For family units of more than 8 members, add $4,060 for each additional member.

MONTHLY GUIDELINES

FAMILY SIZE	PERCENT OF POVERTY GUIDELINE								
	100%	120%	133%	135%	150%	175%	185%	200%	250%
1	972.50	1,167.00	1,293.43	1,312.88	1,458.75	1,701.88	1,799.13	1,945.00	2,431.25
2	1,310.83	1,573.00	1,743.41	1,769.63	1,966.25	2,293.96	2,425.04	2,621.67	3,277.08
3	1,649.17	1,979.00	2,193.39	2,226.38	2,473.75	2,886.04	3,050.96	3,298.33	4,122.92
4	1,987.50	2,385.00	2,643.38	2,683.13	2,981.25	3,478.13	3,676.88	3,975.00	4,968.75
5	2,325.83	2,791.00	3,093.36	3,139.88	3,488.75	4,070.21	4,302.79	4,651.67	5,814.58
6	2,664.17	3,197.00	3,543.34	3,596.63	3,996.25	4,662.29	4,928.71	5,328.33	6,660.42
7	3,002.50	3,603.00	3,993.33	4,053.38	4,503.75	5,254.38	5,554.63	6,005.00	7,506.25
8	3,340.83	4,009.00	4,443.31	4,510.13	5,011.25	5,846.46	6,180.54	6,681.67	8,352.08

Produced by: CMCS/CAHPG/DEEO

2014 Dual Eligible Standards

	Qualifed Medicare Beneficiary (QMB)		Specified Low-Income Medicare Beneficiary (SLMB)		Qualifying Individuals (QI)		Qualified Disabled Working Individuals (QDWI)	
	Single	Couple	Single	Couple	Single	Couple	Single	Couple
Income:								
All *(Except AK & HI)*	993	1,331	1,187	1,593	1,333	1,790	3,975	5,329
Alaska	1,235	1,659	1,478	1,986	1,661	2,232	4,945	6,639
Hawaii	1,139	1,528	1,362	1,829	1,530	2,056	4,559	6,115
Resources:	$7,160	$10,750	$7,160	$10,750	$7,160	$10,750	$4,000	$6,000

IMPORTANT FINANCIAL INFORMATION

Visit the Insurance Verification Representative/ Financial Counselor located in the Admitting Office or call 301-203-2271 or 2154, if you need assistance with:

- Understanding your hospital bill;
- Your rights and obligations with regard to your hospital bill;
- How to apply for free and reduced cost care;
- How to apply for the Maryland Medical Assistance Program and any other programs that may help pay the bill.

If it is after hours, a holiday or a weekend, you can pick up/drop off an application at FWMC's Registration or Information desk. If you need additional assistance, please call and leave a message with a Financial Counselor and someone will return your call within two business days.

Maryland Medical Assistance Program (HealthChoice):
1-800-977-7388 (TDD 1-800-977-7389)

All determinations of eligibility are solely at the discretion of FWMC.

This information is to be provided to the patient, the patient's family/significant other, or the patient's authorized representative before discharge or upon request.

FWMC
FORT WASHINGTON MEDICAL CENTER
A Nexus Health Company

BILLING INSTRUCTIONS on how to obtain financial information is communicated on the first hospital bill. Physician charges are not included in the hospital bill and are billed separately.

EXCLUSION: FWMC has the option to designate certain elective procedures for which no financial assistance option will be given.

TERMS OF AGREEMENT FOR FINANCIAL ASSISTANCE: Financial Assistance will remain valid for three months based on the initial date of the final determination letter. For recurring patients, patients may qualify for Financial Assistance for up to six months on the basis of a single application.

FWMC
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A Nexus Health Company

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11711 Livingston Road
Fort Washington, MD 20744
(301) 292-7000 • www.fortwashingtonmc.org

Find us on Facebook

Financial Assistance
PROGRAM & PRACTICES

at Fort Washington Medical Center

FINANCIAL ASSISTANCE PLAN

Fort Washington Medical Center (FWMC) follows a specific and compassionate policy for payment practices for financial assistance and uninsured billing. As a not-for-profit organization, one of the ways FWMC demonstrates its commitment to the community is through providing financial assistance to those in need. Our practices are an outgrowth of our mission and values.

FWMC'S RESPONSIBILITIES:

- FWMC will serve all patients regardless of their ability to pay.
- Be respectful of the individual's personal dignity and his/her ability to pay.
- Treat all patients equitably, whether insured, underinsured or uninsured.
- Consider the financial resources of patients and their families when establishing a maximum annual patient responsibility.
- Be diligent in our efforts to keep patients notified of their payment options and the opportunities for assistance.
- Ensure that our policies are consistent with the guidelines that have been issued by the American Hospital Association, federal, state and local legislative bodies, and other organizations.
- Provide financial assistance to those in need.

PATIENT'S RESPONSIBILITIES:

- Follow through with the application process.
- Provide all required documents necessary in order to be granted financial assistance.

FWMC PROCEDURE SUMMARY:

1. **An evaluation for financial assistance will be conducted when a:**
   - Patient with a self-pay balance due notifies Patient Accounts that he/she cannot afford to pay the bill and requests assistance.
   - Patient presents at registration or a clinical area without insurance and states that he/she cannot afford to pay the medical expenses.
   - Physician or other clinician refers a patient for a financial assistance evaluation.

2. **A Financial Counselor/Insurance Verification Representative will meet with the patient, upon request, to provide instructions on the Financial Assistance Application.** If it is after hours, a holiday or a weekend, the patient will be issued a copy of the Financial Assistance Program brochure and referred to call 301-203-2271 or 2154 and someone will contact them within two business days.

3. **To make a determination of probable eligibility for Financial Assistance, the applicant must complete the Maryland State Uniform Application for Financial Assistance.**
   - The Insurance Verification Representative/Financial Counselor will perform an assessment to determine if the patient meets preliminary criteria based on the family size/income as defined by Medicaid regulations.
   - A Letter of Conditional Approval for probable eligibility will be sent to the patient within two business days. The person seeking assistance may also call Insurance Verification at the end of the second business day to learn of the determination.
   - Applications received and preliminary determinations made by the Insurance Verification Representative/Financial Counselor will be sent daily to Patient Accounts for review.

4. **During the final determination of eligibility, the patient must provide a copy of the following to the Financial Counselor:**
   - Most recent Federal Income Tax Return.
   - Three most recent pay stubs (if employed).
   - Medical Assistance Notice of Determination (if applicable).
   - Proof of disability income (if applicable).
   - Reasonable proof of other declared expenses.

5. **The following are also necessary for a final determination:**
   - The patient must apply for Medical Assistance unless the Financial Counselor can readily determine that the patient would fail to meet the disability requirement.
   - Review possibility of a reasonable payment plan agreement.
   - All insurance benefits have been exhausted.

6. **The completed Maryland State Uniform Financial Assistance Application and required forms will be forwarded from the Financial Counselor to the Director of Patient Accounts for approval.**

7. **A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses.**

8. **Once a patient is approved for Financial Assistance, it is expected that the patient will continue to meet his/her required financial commitments to FWMC.** If a patient does not make the required payment within 60 days, the Financial Assistance allowance will be reversed and the patient will owe the entire amount. It is recommended that the patient make a good faith payment at the beginning of the Financial Assistance period.

FORT WASHINGTON MEDICAL CENTER
FINANCIAL ASSISTANCE PROGRAM

NOTICE TO PATIENTS

This hospital serves all patients regardless of ability to pay.

Financial assistance for essential services are offered depending on family size and income.

Within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospital will make a determination of probable eligibility.

You may apply for financial assistance at the front desk.

AVISO PARA LOS PACIENTES (Spanish)

Este hospital sirve a todos los pacientes independientemente de la capacidad de pago. Asistencia financiera para los servicios esenciales se ofrecen dependiendo del ingreso y tamaño de la familia.

Dentro de dos días hábiles tras la petición de un paciente para servicios de cuidado de caridad, solicitud de asistencia médica o ambos, el hospital hará una determinación de elegibilidad probable.

Usted puede solicitar asistencia financiera en la recepción.

PAALA SA PASYENTE (Tagalog)

Ang ospital na ito ay nagsisilbi sa lahat. Kahit walang kakayahang magbayad. Nagbibigay rin ang ospital ng bawas sa halaga ng serbisyo.

Depende sa laki ng pamilya at suweldo. Magpunta lang po sa front desk

para makakuha ng impormasyon.

ATTACHMENT C

MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF HEALTH CARE QUALITY

SPRING GROVE CENTER
BLAND BRYANT BUILDING
55 WADE AVENUE
CATONSVILLE, MARYLAND 21228

License No. 16003

Issued to:

Fort Washington Hospital
11711 Livingston Road
Fort Washington, MD 20744

Type of Facility: Acute General Hospital

Date Issued: February 22, 2013

Authority to operate in this State is granted to the above entity pursuant to The Health-General Article, Title 19 Section 318 Annotated Code of Maryland, 1982 Edition, and subsequent supplements and is subject to any and all statutory provisions, including all applicable rules and regulations promulgated thereunder. This document is not transferable.

Expiration Date: May 22, 2016

Patricia Tomasko Nagy MD

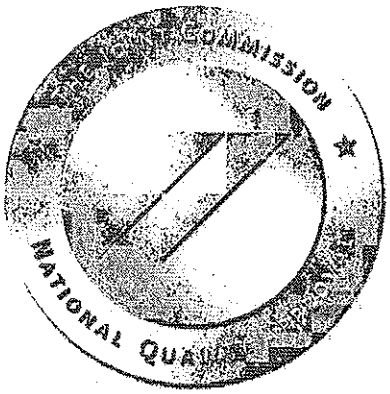
Director

Falsification of a license shall subject the perpetrator to criminal prosecution and the imposition of civil fines.

Fort Washington Medical Center

Fort Washington, MD

has been Accredited by



The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Hospital Accreditation Program

February 22, 2013

Accreditation is customarily valid for up to 36 months.

Rebecca J. Patchin, M.D.
Chair, Board of Commissioners

Organization ID #35331
Print/Reprint Date: 04/26/13

Mark R. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit, national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

ATTACHMENT D

PROJECTED MSGA ADMISSIONS

	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	Totals
Prior Year Admissions	2,306	2,220	2,034	1,874	1,802	1,785	2,306
Reductions - Due to Physician Retirements	(48)	(32)	(23)	(8)	(25)	(25)	(161)
Admissions - Recruited Physicians	26	19	34	52	62	62	255
Reductions - Potentially Avoidable Cases	(64)	(173)	(171)	(116)	(54)	-	(578)
Total Admissions	2,220	2,034	1,874	1,802	1,785	1,822	1,822
						Change from CY 2013	(484)
						% Change from CY 2013	-21.0%
						Compounded Rate of Change CY 2013 - 2019	-3.9%
CMI	0.7966	0.7971	0.8115	0.8477	0.8732	0.8877	
Case Mix Adjusted Discharges (CMADs)	1,768	1,621	1,521	1,528	1,559	1,617	1,617
SFY 2013 Admissions	2,237					Change from SFY 2013	(164)
SFY 2013 CMADs	1,781					% Change from SFY 2013	-9.2%
						Compounded Rate of Change SFY 2013 - CY 2019	-1.5%

ATTACHMENT E

FORT WASHINGTON MEDICAL CENTER
OBSERVATION PATIENTS BY DAY
FOR THE YEAR ENDED DECEMBER 31, 2013

Date	January	February	March	April	May	June	July	August	September	October	November	December	Totals	Average
1	3	10	5	4	5	9	7	3	7	2	3	7	65	5.4
2	7	7	3	8	7	13	8	4	6	4	5	6	78	6.5
3	8	9	7	4	3	11	6	6	12	8	5	7	86	7.2
4	2	10	7	7	10	9	8	6	8	5	8	4	84	7.0
5	4	6	5	5	4	10	8	3	9	8	6	7	75	6.3
6	7	5	9	9	9	7	6	7	10	5	6	7	87	7.3
7	8	9	8	7	10	4	7	7	9	6	3	3	81	6.8
8	11	7	4	7	8	6	4	4	5	4	3	4	67	5.6
9	10	7	6	7	9	4	9	6	5	5	8	6	82	6.8
10	7	3	0	7	7	6	9	8	7	4	7	13	78	6.5
11	7	8	4	7	2	8	5	10	6	6	5	4	72	6.0
12	10	7	4	9	2	5	4	10	9	5	6	4	75	6.3
13	10	7	8	10	4	5	7	8	9	4	9	5	86	7.2
14	10	4	8	9	4	6	9	3	8	4	10	6	81	6.8
15	6	5	4	12	6	8	9	9	6	4	6	5	80	6.7
16	7	2	5	10	7	6	12	6	7	7	8	4	81	6.8
17	7	2	6	6	8	12	11	5	9	7	8	5	86	7.2
18	9	5	5	9	5	12	8	4	15	6	6	6	90	7.5
19		6	6	6	8	13	7	3	8	4	4	10	75	6.3
20	6	3	5	7	9	11	6	6	7	4	4	10	78	6.5
21	6	6	3	7	10	7	7	10	1	7	4	8	76	6.3
22	4	8	5	5	14	9	11	8	2	4	5	4	79	6.6
23	5	6	3	6	7	8	9	8	11	6	6	5	80	6.7
24	6			6	7	8	6	6	11	6	7	3	66	5.5
25	4	9	3	4	12	11	7	5	11	7	5	1	79	6.6
26		7	4	5	9	10	7	8	8	8	4	1	71	5.9
27	10	10	7	6	8	7	6	8	7	11	8	7	95	7.9
28	6	7	7	11	5	11	6	7	5	3	6	2	76	6.3
29	5		7	15	7	9	7	2	7	3	6	2	70	5.8
30	4		3	11	9	14		3		7	4	2	57	4.8
31	6		4		12			8		3		4	37	3.1
	195	175	155	226	227	259	216	191	225	167	175	162	2373	197.8

Note: The count of patients will not equal the statistics for equivalent patient days because the days are based on total hours, not actual patients in beds as shown in this chart.

ATTACHMENT F

Hilary Herbert Washington, M.D.
11701 Livingston Road
Suite 205
Fort Washington, MD 20744
(301) 292-6332

December 10, 2014

Mr. Paul Parker
Director, CON Program
Maryland Health Care Commission
4.150 Patterson Avenue Baltimore, MD 21215
Baltimore, MD 21215

Re: CON Application for the Proposed Expansion of FWMC

Dear Mr. Parker

I am a physician on staff at Fort Washington Medical Center (FWMC) specializing in Family Practice Medicine. My Practice has been located in the Fort Washington area for more than 15 years.

I'm sending you this letter to express my support of the FWMC plan to expand, modernize and upgrade the Surgery department, Emergency Department, and the conversion of the inpatient rooms from dual occupancy to single occupancy. Once the plan is completed I expect Inpatient satisfaction will improve based on the conversion to single rooms.

I believe that the proposed plan to upgrade and expand the FWMC physical plant will be a welcome complementary alternative to other area hospitals, and will be an important essential resource for my patients, my practice and the community at-large.

I urge you to approve the Certificate of Need application submitted by FWMC. Should you have any questions, please contact me.

Sincerely,

Hilary Herbert Washington, M.D.

HHW/bs

ATTACHMENT G

FORT WASHINGTON MEDICAL CENTER

PROJECTION GBR REVENUE - State Fiscal Year Basis

	SFY 6/30/2014 as of 7/1/2013	SFY 6/30/2015	SFY 6/30/2016	SFY 6/30/2017	SFY 6/30/2018	SFY 6/30/2019
Permanent Revenue, includes assessments	$ 47,020,000	$ 46,750,000	$ 47,626,000	$ 48,097,000	$ 48,573,000	$ 49,054,000
Full Inflation Provision	719,000 *	1,127,000 *	-	-	-	-
Subtotal	47,739,000	47,877,000	47,626,000	48,097,000	48,573,000	49,054,000
Population Adjustment	(989,000) *	474,000 **	471,000 **	476,000 **	481,000 **	486,000 **
Subtotal	46,750,000	48,351,000	48,097,000	48,573,000	49,054,000	49,540,000
Slippage	-	(63,000) ***	-	-	-	-
Subtotal	46,750,000	48,288,000	48,097,000	48,573,000	49,054,000	49,540,000
GBR Investment	-	-	-	-	-	-
Subtotal	46,750,000	48,288,000	48,097,000	48,573,000	49,054,000	49,540,000
Change in Markup	-	(291,000) *****	-	-	-	-
Subtotal	46,750,000	47,997,000	48,097,000	48,573,000	49,054,000	49,540,000
Assessment Changes, (predominantly MHIP)	-	(371,000) ****	-	-	-	-
Subtotal Permanent GPSR	46,750,000	47,626,000	48,097,000	48,573,000	49,054,000	49,540,000
One Time Adjustments:						
MHAC/QBR Scaling	46,000	(203,000) *	-	-	-	-
Undercharge at 6/30/2014; all recovered by 12/31/2014	(1,072,000)	1,072,000 *	-	-	-	-
Grand Total, Compliance GPSR	$ 45,724,000	$ 48,495,000	$ 48,097,000	$ 48,573,000	$ 49,054,000	$ 49,540,000

Convert GBR Revenue Target to CY	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019
CY GBR Revenue Target	$ 47,109,500	$ 47,760,000	$ 48,335,000	$ 48,813,500	$ 49,297,000	$ 49,785,000
% Increase per Annum		1.38%	1.20%	0.99%	0.99%	0.99%

	SFY 6/30/2014	SFY 6/30/2015	SFY 6/30/2016	SFY 6/30/2017	SFY 6/30/2018	SFY 6/30/2019
Total Permanent Increase Per Annum	$ (270,000)	$ 876,000	$ 471,000	$ 476,000	$ 481,000	$ 486,000
Revenue Component Increase	1.529%	1.653%	0.000%	0.000%	0.000%	0.000%
Volume Component Increase	-2.103%	1.014%	0.989%	0.990%	0.990%	0.991%
Overall % Increase to Permanent Revenue	-0.574%	1.874%	0.989%	0.990%	0.990%	0.991%

Assumed Permanent Increases:	SFY 6/30/2014	SFY 6/30/2015	SFY 6/30/2016	SFY 6/30/2017	SFY 6/30/2018	SFY 6/30/2019
Full Inflation Provision	1.530%	2.410%	0.000%	0.000%	0.000%	0.000%
Population Adjustment	-2.071%	0.990%	0.990%	0.990%	0.990%	0.990%
Slippage	0.000%	-0.130%	0.000%	0.000%	0.000%	0.000%
GBR Investment	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%
Change in Markup	0.000%	-0.602%	0.000%	0.000%	0.000%	0.000%
Assessment Changes (predominantly MHIP)	0.000%	-0.790%	0.000%	0.000%	0.000%	0.000%
Total Permanent Changes	-0.541%	1.878%	0.990%	0.990%	0.990%	0.990%

NOTES:

* Computed by the HSCRC.
** .99% per year - computed by HSCRC for FWMC's 2015 GBR, Used same for 2016 moving forward

*** Computed by the HSCRC for 2015 GBR. Represents system adjustments as developed by HSCRC

**** Computed by the HSCRC for 2015 GBR. Represents various system changes; predominantly related to MHIP

***** Computed by the HSCRC for 2015 GBR. Represents impacdt of changes in payor mix and uncompensated care.

ATTACHMENT H

FORT WASHINGTON MEDICAL CENTER
CON
PART II - PROJECT BUDGET
(INSTRUCTION: All estimates for 1.a.-e., 2.a.-h., and 3 are for current costs as of the date of

		Hospital Expansion (with 2nd Floor Nursing Unit Removed
A.	Uses of Funds	
1.	Capital Costs	
	a. New Construction	
	(1) Building & Fixed Equipment	$ 4,700,449
	(2) Fixed Equipment (Not Included in Construction)	757,201
	(3) Land Purchase	N/A
	(4) Site Preparation - Land Improvements	604,302
	(5) Architect/Engineering Fees	1,087,429
	(6) Permits, (Building, Utilities, Etc.)	181,240
	SUBTOTAL (a)	7,330,621
	b. Renovations	
	(1) Building & Fixed Equipment	1,887,515
	(2) Fixed Equipment (Not Included in Construction)	99,363
	(3) Architect/Engineering Fees	238,420
	(4) Permits, (Building, Utilities, Etc.)	39,737
	SUBTOTAL (b)	2,265,035
	c. Other Capital Costs	
	(1) Major Movable Equipment	1,531,680
	(2) Minor Movable Equipment	522,230
	(3) Contingencies	1,558,563
	(4) Other (Specify)	
	a. Furniture (Dining/lobby)	359,760
	b. Interior & Exterior Signage	63,870
	c. IT and Telecommunications	159,670
	d. Security system	95,800
	e. Relocation expense	154,180
	f. Certifications, testing & inspection, etc.	51,390
	g. Other Miscellaneous	51,390
	SUBTOTAL (c)	4,548,533
	TOTAL CURRENT CAPITAL COSTS (a-c)	$ 14,144,189
	d. Non Current Capital Cost	
	(1) Interest (Gross)	681,000
	(1)a Amount Included on 1.d.(1) That is Related to Post Construction	(132,000)
	(2) Inflation Allowance (2.7% for 2013; 2.7% for 2014; 1.35% for 2015 to midpoint of construction	930,986
	TOTAL PROPOSED CAPITAL COSTS (a-d)	$ 15,624,175
2.	Financing Cost and Other Cash Requirements	
	a. Loan Placement Fees	771,000
	b. Bond Discount	-
	c. Bond Financing Expenses	-
	d. Legal Fees (Other)	-
	e. Printing	-
	f. Consultant Fees:	
	CON Application Assistance	150,000
	Other (Specify)	-
	g. Liquidation of Existing Debt	-
	h. Debt Service Reserve Fund	-
	I. Principal Amortization	-
	Reserve Fund	-
	j. Other (Specify)	
	HUD AMPO Fund	318,000
	TOTAL (a - j)	$ 1,239,000
3.	Working Capital/ Startup Costs	
	Working Capital	$ -
	Amount Borrowed For Interest Payments After Completion of Construction	132,000
	TOTAL USES OF FUNDS (1 - 3)	$ 16,995,175

B.	Sources of Funds for Project:		
1.	Cash	$	560,000
2.	Pledges: Gross _____, less allowance for uncollectibles $0, =		-
3.	Gifts, bequests - State of Maryland ED Grant		560,000
4.	Interest income (gross)		-
5.	Authorized Bonds		-
6.	Taxable FHA/GNMA Debt		15,875,175
7.	Net Working Capital Transferred from Adventist HealthCare		
8.	Grants or Appropriation		
	(a) Federal		-
	(b) State		-
	(c) Local		-
9.	Other:		
	(a)		-
	(b)		-
	TOTAL SOURCES OF FUNDS (1 - 9)	$	16,995,175

Lease Costs:	
a) Land	N/A
b) Building	N/A
C) Major Movable Equipment	N/A
d) Minor Movable Equipment	N/A
e) Other	N/A

REVISED - Table 3. Revenue and Expenses - Entire Facility (Including Proposed Project) in thousands											
_X_CY or __ FY		Most Recent Ended Actual Years				Projected Years (ending with first full year at full utilization)					
Check		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
1.	Revenue										
a.	Inpatient	$ 23,220	$ 21,305	$ 17,619	$ 19,189	$ 18,775	$ 18,118	$ 17,680	$ 17,968	$ 18,175	$ 18,581
b.	Outpatient	21,528	25,860	28,557	26,967	28,335	29,642	30,655	30,846	31,122	31,204
c.	Gross patient service revenue	44,748	47,165	46,176	46,156	47,110	47,760	48,335	48,814	49,297	49,785
d.	Allowance for bad debt expense	3,243	3,582	2,099	1,851	1,394	1,399	1,416	1,430	1,444	1,459
e.	Contractual allowances	4,090	4,703	5,039	5,287	5,308	5,081	5,021	4,949	4,875	4,923
f.	Charity care	603	688	1,497	1,660	1,695	1,718	1,739	1,756	1,773	1,791
g.	Net patient service revenue	36,812	38,192	37,541	37,358	38,713	39,562	40,159	40,679	41,205	41,612
h.	Other operating revenue (Specify):										
	Other operating revenue - schedule attached	1,297	1,257	2,367	2,149	2,146	1,395	1,008	966	911	919
	Interest income-trustee funds	-	-	-	-	8	8	8	9	10	11
i.	Net operating revenue	$ 38,109	$ 39,449	$ 39,908	$ 39,507	$ 40,867	$ 40,965	$ 41,175	$ 41,654	$ 42,126	$ 42,542
2.	Expenses										
a.	Salaries, wages, and professional fees (including fringe benefits)	$ 21,345	$ 21,676	$ 22,348	$ 21,574	$ 21,970	$ 21,429	$ 20,861	$ 21,063	$ 21,522	$ 21,997
b.	Contractual services - Purchased labor agency	6	-	-	1	-	-	-	-	-	-
c.	Interest on current debt	637	613	610	557	395	375	355	336	318	300
d.	Interest on project debt - including MIP and fees	-	-	-	-	-	-	-	865	847	827
e.	Current depreciation	1,061	695	701	711	781	874	967	1,063	1,161	1,216
f.	Project depreciation	-	-	-	-	-	-	-	789	789	789
g.	Current amortization	90	90	90	90	90	90	90	90	90	90
h.	Project amortization	-	-	-	-	-	-	-	61	59	58
i.	Supplies	6,048	6,000	5,598	5,566	5,757	5,587	5,466	5,458	5,539	5,651
j.	Other expenses:										
	Insurance	860	874	873	893	921	912	903	896	897	901
	Utilities	644	681	621	652	704	683	663	600	602	609
	Physician professional fees	468	664	743	749	903	1,432	1,889	1,627	1,376	1,026
	Contracted services	4,906	5,183	5,212	5,760	5,754	5,543	5,330	5,195	5,204	5,248
	Rent	930	1,109	1,200	1,210	1,228	1,153	1,123	1,123	1,123	1,123
	Other	718	895	810	1,169	1,224	1,201	1,044	1,030	1,031	1,040
k.	Total operating expenses	$ 37,713	$ 38,480	$ 38,806	$ 38,932	$ 39,727	$ 39,279	$ 38,691	$ 40,196	$ 40,558	$ 40,875
3.	Income										
a.	Income from operations	$ 396	$ 969	$ 1,102	$ 575	$ 1,140	$ 1,686	$ 2,484	$ 1,458	$ 1,568	$ 1,667
b.	Nonoperating income/expense:										
	Interest income	5	4	1	1	13	20	26	37	44	56
	Loss on debt extinguishment	-	-	-	-	-	-	-	-	-	-
c.	Subtotal	401	973	1,103	576	1,153	1,706	2,510	1,495	1,612	1,723
d.	Income Taxes	-	-	-	-	-	-	-	-	-	-
e.	Net Income (Loss)	$ 401	$ 973	$ 1,103	$ 576	$ 1,153	$ 1,706	$ 2,510	$ 1,495	$ 1,612	$ 1,723

(Continued)

FWMC Reduce Project Alternative - Created 12/12/14
Including Inflation

REVISED - Table 3. Revenue and Expenses - Entire Facility (Including Proposed Project) in thousands

_X_CY or __ FY	Most Recent Ended Actual Years				Projected Years (ending with first full year at full utilization)					
Check	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
1. Revenue										
a. Inpatient	$ 23,220	$ 21,305	$ 17,619	$ 19,189	$ 18,775	$ 18,387	$ 18,409	$ 19,133	$ 19,795	$ 20,698
b. Outpatient	21,528	25,860	28,557	26,967	28,335	30,081	31,918	32,849	33,896	34,760
c. Gross patient service revenue	44,748	47,165	46,176	46,156	47,110	48,468	50,327	51,982	53,691	55,458
d. Allowance for bad debt expense	3,243	3,582	2,099	1,851	1,394	1,420	1,475	1,523	1,573	1,625
e. Contractual allowances	4,090	4,703	5,039	5,287	5,308	5,156	5,228	5,270	5,309	5,484
f. Charity care	603	688	1,497	1,660	1,695	1,744	1,811	1,870	1,932	1,995
g. Net patient service revenue	36,812	38,192	37,541	37,358	38,713	40,148	41,813	43,319	44,877	46,354
h. Other operating revenue (Specify):										
Other operating revenue - schedule attached	1,297	1,257	2,367	2,149	2,146	1,423	1,054	1,039	1,012	1,052
Interest income-trustee funds	-	-	-	-	8	8	8	9	10	11
I. Net operating revenue	$ 38,109	$ 39,449	$ 39,908	$ 39,507	$ 40,867	$ 41,579	$ 42,875	$ 44,367	$ 45,899	$ 47,417
2. Expenses										
a. Salaries, wages, and professional fees (including fringe benefits)	$ 21,345	$ 21,676	$ 22,348	$ 21,574	$ 21,862	$ 21,537	$ 21,176	$ 21,595	$ 22,286	$ 23,006
b. Contractual services - Purchased labor agency	6	-	-	1	-	-	-	-	-	-
c. Interest on current debt	637	613	610	557	395	375	355	336	318	300
d. Interest on project debt - including MIP and fees	-	-	-	-	-	-	-	865	847	827
e. Current depreciation	1,061	695	701	711	781	874	967	1,063	1,161	1,216
f. Project depreciation	-	-	-	-	-	-	-	789	789	789
g. Current amortization	90	90	90	90	90	90	90	90	90	90
h. Project amortization	-	-	-	-	-	-	-	61	59	58
I. Supplies	6,048	6,000	5,598	5,566	5,757	5,755	5,799	5,964	6,234	6,551
j. Other expenses:										
Insurance	860	874	873	893	925	937	948	963	988	1,017
Utilities	644	681	621	652	704	704	703	660	682	711
Physician professional fees	468	664	743	749	903	1,432	1,889	1,627	1,376	1,026
Contracted services	4,906	5,183	5,212	5,760	5,784	5,700	5,609	5,595	5,744	5,938
Rent	930	1,109	1,200	1,210	1,234	1,187	1,183	1,210	1,240	1,271
Other	718	895	810	1,169	1,231	1,234	1,104	1,113	1,143	1,181
k. Total operating expenses	$ 37,713	$ 38,480	$ 38,806	$ 38,932	$ 39,666	$ 39,825	$ 39,823	$ 41,931	$ 42,957	$ 43,981
3. Income										
a. Income from operations	$ 396	$ 969	$ 1,102	$ 575	$ 1,201	$ 1,754	$ 3,052	$ 2,436	$ 2,942	$ 3,436
b. Nonoperating income/expense:										
Interest income	5	4	1	1	13	20	28	42	64	125
Loss on debt extinguishment	-	-	-	-	-	-	-	-	-	-
c. Subtotal	401	973	1,103	576	1,214	1,774	3,080	2,478	3,006	3,561
d. Income Taxes	-	-	-	-	-	-	-	-	-	-
e. Net Income (Loss)	$ 401	$ 973	$ 1,103	$ 576	$ 1,214	$ 1,774	$ 3,080	$ 2,478	$ 3,006	$ 3,561

(Continued)

ATTACHMENT I

REVISED - Table 3. Revenue and Expenses - Entire Facility (Including Proposed Project) in thousands										
_X_CY or __ FY	Most Recent Ended Actual Years				Projected Years (ending with first full year at full utilization)					
Check	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
1. Revenue										
a. Inpatient	$ 23,220	$ 21,305	$ 17,619	$ 19,189	$ 18,775	$ 18,118	$ 17,680	$ 17,968	$ 18,175	$ 18,581
b. Outpatient	21,528	25,860	28,557	26,967	28,335	29,642	30,655	30,846	31,122	31,204
c. Gross patient service revenue	44,748	47,165	46,176	46,156	47,110	47,760	48,335	48,814	49,297	49,785
d. Allowance for bad debt expense	3,243	3,582	2,099	1,851	1,394	1,399	1,416	1,430	1,444	1,459
e. Contractual allowances	4,090	4,703	5,039	5,287	5,308	5,081	5,021	4,949	4,875	4,923
f. Charity care	603	688	1,497	1,660	1,695	1,718	1,739	1,756	1,773	1,791
g. Net patient service revenue	36,812	38,192	37,541	37,358	38,713	39,562	40,159	40,679	41,205	41,612
h. Other operating revenue (Specify):										
Other operating revenue - schedule attached	1,297	1,257	2,367	2,149	2,146	1,395	1,008	966	911	919
Interest income-trustee funds	-	-	-	-	8	8	8	9	10	11
I. Net operating revenue	$ 38,109	$ 39,449	$ 39,908	$ 39,507	$ 40,867	$ 40,965	$ 41,175	$ 41,654	$ 42,126	$ 42,542
2. Expenses										
a. Salaries, wages, and professional fees (including fringe benefits)	$ 21,345	$ 21,676	$ 22,348	$ 21,574	$ 21,970	$ 21,429	$ 20,861	$ 21,063	$ 21,522	$ 21,997
b. Contractual services - Purchased labor agency	6	-	-	1	-	-	-	-	-	-
c. Interest on current debt	637	613	610	557	395	375	355	336	318	300
d. Interest on project debt - including MIP and fees	-	-	-	-	-	-	-	1,052	1,030	1,006
e. Current depreciation	1,061	695	701	711	781	874	967	1,063	1,161	1,216
f. Project depreciation	-	-	-	-	-	-	-	906	906	906
g. Current amortization	90	90	90	90	90	90	90	90	90	90
h. Project amortization	-	-	-	-	-	-	-	74	72	70
I. Supplies	6,048	6,000	5,598	5,566	5,757	5,587	5,466	5,458	5,539	5,651
j. Other expenses:										
Insurance	860	874	873	893	921	912	903	896	897	901
Utilities	644	681	621	652	704	683	663	648	650	658
Physician professional fees	468	664	743	749	903	1,432	1,889	1,627	1,376	1,026
Contracted services	4,906	5,183	5,212	5,760	5,754	5,543	5,330	5,255	5,264	5,309
Rent	930	1,109	1,200	1,210	1,228	1,153	1,123	1,123	1,123	1,123
Other	718	895	810	1,169	1,224	1,201	1,044	1,030	1,031	1,040
k. Total operating expenses	$ 37,713	$ 38,480	$ 38,806	$ 38,932	$ 39,727	$ 39,279	$ 38,691	$ 40,621	$ 40,979	$ 41,293
3. Income										
a. Income from operations	$ 396	$ 969	$ 1,102	$ 575	$ 1,140	$ 1,686	$ 2,484	$ 1,033	$ 1,147	$ 1,249
b. Nonoperating income/expense:										
Interest income	5	4	1	1	13	20	26	36	42	47
Loss on debt extinguishment	-	-	-	-	-	-	-	-	-	-
c. Subtotal	401	973	1,103	576	1,153	1,706	2,510	1,069	1,189	1,296
d. Income Taxes	-	-	-	-	-	-	-	-	-	-
e. Net Income (Loss)	$ 401	$ 973	$ 1,103	$ 576	$ 1,153	$ 1,706	$ 2,510	$ 1,069	$ 1,189	$ 1,296

REVISED - Table 3. Revenue and Expenses - Entire Facility (Including Proposed Project) in thousands										
_X_CY or __ FY	Most Recent Ended Actual Years				Projected Years (ending with first full year at full utilization)					
Check	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
1. Revenue										
a. Inpatient	$ 23,220	$ 21,305	$ 17,619	$ 19,189	$ 18,775	$ 18,387	$ 18,409	$ 19,133	$ 19,795	$ 20,698
b. Outpatient	21,528	25,860	28,557	26,967	28,335	30,081	31,918	32,849	33,896	34,760
c. Gross patient service revenue	44,748	47,165	46,176	46,156	47,110	48,468	50,327	51,982	53,691	55,458
d. Allowance for bad debt expense	3,243	3,582	2,099	1,851	1,394	1,420	1,475	1,523	1,573	1,625
e. Contractual allowances	4,090	4,703	5,039	5,287	5,308	5,156	5,228	5,270	5,309	5,484
f. Charity care	603	688	1,497	1,660	1,695	1,744	1,811	1,870	1,932	1,995
g. Net patient service revenue	36,812	38,192	37,541	37,358	38,713	40,148	41,813	43,319	44,877	46,354
h. Other operating revenue (Specify):										
Other operating revenue - schedule attached	1,297	1,257	2,367	2,149	2,146	1,423	1,054	1,039	1,012	1,052
Interest income-trustee funds	-	-	-	-	8	8	8	9	10	11
I. Net operating revenue	$ 38,109	$ 39,449	$ 39,908	$ 39,507	$ 40,867	$ 41,579	$ 42,875	$ 44,367	$ 45,899	$ 47,417
2. Expenses										
a. Salaries, wages, and professional fees (including fringe benefits)	$ 21,345	$ 21,676	$ 22,348	$ 21,574	$ 21,862	$ 21,537	$ 21,176	$ 21,595	$ 22,286	$ 23,006
b. Contractual services - Purchased labor agency	6	-	-	1	-	-	-	-	-	-
c. Interest on current debt	637	613	610	557	395	375	355	336	318	300
d. Interest on project debt - including MIP and fees	-	-	-	-	-	-	-	1,052	1,030	1,006
e. Current depreciation	1,061	695	701	711	781	874	967	1,063	1,161	1,216
f. Project depreciation	-	-	-	-	-	-	-	906	906	906
g. Current amortization	90	90	90	90	90	90	90	90	90	90
h. Project amortization	-	-	-	-	-	-	-	74	72	70
I. Supplies	6,048	6,000	5,598	5,566	5,757	5,755	5,799	5,964	6,234	6,551
j. Other expenses:										
Insurance	860	874	873	893	925	937	948	963	988	1,017
Utilities	644	681	621	652	704	704	703	709	732	763
Physician professional fees	468	664	743	749	903	1,432	1,889	1,627	1,376	1,026
Contracted services	4,906	5,183	5,212	5,760	5,784	5,700	5,609	5,654	5,805	6,002
Rent	930	1,109	1,200	1,210	1,234	1,187	1,183	1,210	1,240	1,271
Other	718	895	810	1,169	1,231	1,234	1,104	1,113	1,143	1,181
k. Total operating expenses	$ 37,713	$ 38,480	$ 38,806	$ 38,932	$ 39,666	$ 39,825	$ 39,823	$ 42,356	$ 43,381	$ 44,405
3. Income										
a. Income from operations	$ 396	$ 969	$ 1,102	$ 575	$ 1,201	$ 1,754	$ 3,052	$ 2,011	$ 2,518	$ 3,012
b. Nonoperating income/expense:										
Interest income	5	4	1	1	13	20	28	41	54	106
Loss on debt extinguishment	-	-	-	-	-	-	-	-	-	-
c. Subtotal	401	973	1,103	576	1,214	1,774	3,080	2,052	2,572	3,118
d. Income Taxes	-	-	-	-	-	-	-	-	-	-
e. Net Income (Loss)	$ 401	$ 973	$ 1,103	$ 576	$ 1,214	$ 1,774	$ 3,080	$ 2,052	$ 2,572	$ 3,118